PER

The New York
Academy of Medicine



By Exchange

Digitized by the Internet Archive
in 2016

https://archive.org/details/journalofmedical61unse_0

ANNUAL MEETING — MAY 11 - 15, 1963 — HADDON HALL, ATLANTIC CITY

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Entered as second-class matter September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879
Second Class Postage Paid at Orange, N. J.

VOL. 60, NO. 1 JANUARY, 1963 Subscriptions, $3.00 per year
Single Copies, 30 Cents

60
1963

APR 26 19[illegible]
LIBRARY

CONTENTS—Pages 1 to 50

EDITORIALS— Page

Fussing and Feuding 1
I'll Get Me Such a Colored Periwig 2
Healing Force of Emotion 3

ORIGINAL ARTICLES—

A Plea for Constructive Iconoclasm—Louis S. Wegryn, M.D., Elizabeth 5
Infusion Chemotherapy for Brain and Neck Cancer—Arthur Winter, M.D., East Orange 8
Intra-arterial Chemotherapy—Roy T. Forsberg, M.D., Elizabeth 11
Hemolytic Anemia in Mononucleosis—Donald J. MacPherson, M.D., Hackensack 13
Geriatric Surgery—M. A. Roberts, M.D., Newark 15
Problems of Infertility—S. Leon Israel, M.D., Philadelphia, Pa. 19

ORIGINAL ARTICLES— Page

Radiation Therapy in Skin Disease—Earle W. Brauer, M.D., Jersey City 24
Recent Technics of Tympanoplasty—I. M. Schnee, M.D., Paterson 28
Tracheotomy in the Treatment of Chest Injuries—George N. J. Sommer, Jr., M.D., Trenton 31

STATE ACTIVITIES—

Epilepsy and the Law 34
Trustees' Meeting: October 21, 1962 35
Physician-Hospital Relationships 37
Salute to Old Timers 38
Disclosure by Physicians 39
Strike Back at Arthritis 40

ANNOUNCEMENTS 42
LETTERS TO THE JOURNAL 43
OBITUARIES 44
BOOK REVIEWS 46
RESPIRATORY DISEASE ABSTRACTS 49

Roster of Officers, Advertising Page 3 A

Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.
Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.
Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.
Telephone EXport 4-3154



Published Monthly Since 1904
Acceptance for mailing at special rate of postage provided for in Sec. 1103, Act of Oct. 3, 1917, authorized July 29, 1918.

Copyright 1963 by
The Medical Society of New Jersey

Enrollment Now Under Way! **Enrollment Now Under Way!**

WATCH YOUR MAIL FOR ANNOUNCEMENT FOLDER AND APPLICATION OF

The Medical Society of New Jersey

353801

OFFICIALLY ENDORSED

MAJOR MEDICAL PLAN

Paying 80% of Covered Medical Expenses (Except Physicians' and Surgeons' Fees)

IN OR OUT OF HOSPITAL

N.Y. ACADEMY OF MEDICINE
FEB 10 1964
LIBRARY

UP TO $10,000

after a $500 deductible which may be paid by Hospitalization Insurance, Service Plan or out-of-pocket

THE PLAN COVERS:

DAILY HOSPITAL ROOM AND BOARD
Full charge for ward or semi-private room—private room limit is $30.
MISCELLANEOUS HOSPITAL SERVICES as inpatient or outpatient.
REGISTERED NURSE in and out of hospital.

SERVICES AND SUPPLIES in and out of hospital
Drugs and medicines prepared from a doctor's prescription.
Laboratory and X-ray services, including X-ray and radium treatment.
Anesthesia, oxygen, blood and blood plasma, and surgical dressings.
Artificial limbs and eyes, casts, splints, trusses, braces and crutches; rental of iron lung.
Local professional ambulance transportation to and from a hospital for inpatient treatment.

ANNUAL PREMIUMS AT ENTRY AND FOR RENEWAL AT ATTAINED AGE

Age of Member	Member Only	Member and Spouse	Member, Spouse and Children	Member and Children
Under 40	**$10.40**	**$ 22.20**	**$ 35.00**	**$ 23.20**
40-49	**18.20**	**38.00**	**50.20**	**30.40**
50-59	**32.40**	**66.00**	**78.20**	**44.60**
60-65*	**52.00**	**103.00**	**109.00**	**58.00**

* During the initial enrollment the age limit for policy issuance is the 70th birthday. Although the age limit for policy issuance after the initial enrollment is the 65th birthday, the policy is renewable to 70 at age 60-65 rates.

***Special extension of coverage policy providing coverage beyond age 70 with a maximum benefit of $5000 for each disablement with a $750 deductible, available upon request at that age without evidence of insurability.**

SOME HIGHLIGHTS:

MENTAL DISORDERS are covered up to full $10,000 maximum, if patient is confined in a non-government hospital.

PREGNANCY beginning after insurance in force is covered.

CONGENITAL DEFECTS are covered, if such expenses are incurred either (a) for a child born to a mother who is already insured, or (b) more than three years after the effective date of the Covered Person's insurance.

COSMETIC SURGERY is covered, if the condition to be treated is a result of injury sustained while the Covered Person is insured.

RECURRENT conditions are covered.

NO SPECIFIC LIMIT on number of days in hospital or for professional nursing expense.

WORLDWIDE COVERAGE.

THE EXCLUSIONS:

The plan does not cover expenses which are not reasonable or necessary or caused by or resulting from: the hazards of warfare; injury or sickness contracted while in the armed forces; suicide or attempt thereat; self-inflicted injury; injury or sickness covered by Workmen's Compensation or Occupational Disease Law; supplies or services which are furnished by or at the expense of the Federal Government or an agency thereof; treatment for alcoholism or narcotic addiction; or cosmetic surgery or congenital defects or air travel, except as specified in the policy.

TERMINATION:

As long as the Society's plan remains in force and you remain a member of the Society and pay the required premium, your insurance cannot terminate prior to age 70*. Similarly, dependent insurance continues concurrently with the member's policy as long as the person remains a Dependent as defined if premium is paid.

Full Details of Coverage Are in Policy

Issued by

NATIONAL CASUALTY COMPANY

DETROIT, MICHIGAN

Administered by

E. & W. BLANKSTEEN AGENCY, Inc.
75 Montgomery St., Jersey City 2, N. J.
DElaware 3-4340

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATON, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.
EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154
(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

OFFICERS

President, Louis S. Wegryn, M.D. ..... Elizabeth
President-Elect, Jerome G. Kaufman, M.D. ..... Maplewood
First Vice-President, Charles H. Calvin, M.D. .. Perth Amboy
Second Vice-President, John J. Bedrick, M.D. ..... Bayonne
Secretary, Marcus H. Greifinger, M.D. ..... Newark
Treasurer, Daniel F. Featherston, M.D. ..... Newark
Mr. Richard I. Nevin, *Executive Officer* ..... Trenton
Mrs. Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton

TRUSTEES

Samuel J. Lloyd, M.D., *Chairman* (1963) ..... Trenton
Nicholas A. Bertha, M.D., *Secretary* (1965) ..... Wharton
Louis S. Wegryn, M.D. ..... Elizabeth
Jerome G. Kaufman, M.D. ..... Maplewood
Charles H. Calvin, M.D. ..... Perth Amboy
John J. Bedrick, M.D. ..... Bayonne
Marcus H. Greifinger, M.D. ..... Newark
Daniel F. Featherston, M.D. ..... Asbury Park
Ralph M. L. Buchanan, M.D. ..... Phillipsburg
Louis F. Albright, M.D. (1964) ..... Spring Lake
Louis K. Collins, M.D. (1964) ..... Glassboro
Thomas C. DeCecio, M.D. (1965) ..... Cliffside Park
Joseph P. Donnelly, M.D. (1963) ..... Jersey City
Lloyd A. Hamilton, M.D. (1965) ..... Lambertville
Frank J. Hughes, M.D. (1963) ..... Gloucester
Joseph R. Jehl, M.D. (1963) ..... Clifton
Emanuel M. Satulsky, M.D. (1964) ..... Elizabeth
Carl N. Ware, M.D. (1965) ..... Shiloh

COUNCILORS

First District (Essex, Morris, Union, and Warren Counties) ..... Henry L. Hermann, M.D., Phillipsburg (1963)
Second District (Bergen, Hudson, Passaic, and Sussex Counties) ..... John L. Olpp, M.D., Englewood (1965)
Third District (Hunterdon, Mercer, Middlesex, and Somerset Counties) ..... Albert F. Moriconi, M.D., Trenton (1964)
Fourth District (Burlington, Camden, Monmouth, and Ocean Counties) ..... E. Vernon Davis, M.D., Moorestown (1963)
Fifth District (Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties) .... Isaac N. Patterson, M.D., Westville (1963)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell, M.D. (1964) ..... Asbury Park
William F. Costello, M.D. (1963) ..... Dover
Joseph P. Donnelly, M.D. (1964) ..... Jersey City
Marcus H. Greifinger, M.D. (1964) ..... Newark
L. Samuel Sica, M.D. (1962) ..... Trenton
Isaac N. Patterson, M.D. (1963) ..... Westville

Alternates

F. Clyde Bowers, M.D. (1964) ..... Mendham
Frank J. Hughes, M.D. (1964) ..... Gloucester
Joseph R. Jehl, M.D. (1964) ..... Clifton
John F. Kustrup, M.D. (1964) ..... Trenton
Elton W. Lance, M.D. (1963) ..... Rahway
John L. Olpp, M.D. (1963) ..... Englewood

INFORMATION FOR READERS AND CONTRIBUTORS

The Journal is the official organ of The Medical Society of New Jersey, published monthly under the direction of the Committee on Publication. *The Journal* is released on or about the tenth of each month, and a copy is sent to each member of the Society.

Change of Address: Notice of change of address should be sent promptly to The Medical Society of New Jersey, P.O. Box 904, Trenton 5, New Jersey.

Communications: Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of any material in *The Journal*. All such communications should be directed to the Editorial Office of *The Journal*. The Publication Committee reserves the right to publish, reject, edit or abbreviate all communications submitted to it.

Contributions: Manuscripts submitted to *The Journal* should be typewritten, double-spaced on letter size (about 8¼ by 11 inch) paper and forwarded to the Editorial Office at the address below. The Publication Committee expressly reserves the right to reject any contributions, whether solicited or not; and the right to abbreviate or edit such contributions in conformity with the needs and requirements of *The Journal*. Galley-proofs of edited or abbreviated manuscripts will be submitted to authors for approval before publication. Every care will be taken with the submitted material, but *The Journal* will not hold itself responsible for loss or damage to manuscripts. Authors are required to submit original copies only, and are urged to keep carbon copies for reference. It is understood that material is submitted here for exclusive publication in this *Journal*.

Illustrations: Authors wishing illustrations for their articles will submit glossy prints or original sketches, from which cuts or plates will be made by *The Journal*. The cost of making such cuts will be borne by the author, who will, after publication, receive the cuts for his own use. The cost of these cuts varies with the size and type of the illustration. An estimate of the cost will be submitted to authors before the cuts are ordered.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY
P. O. Box 904, Trenton 5, New Jersey



Colds haven't changed– but relief has with

NTz®

NASAL SPRAY

NTz Nasal Spray provides prompt, dependable decongestion of nasal membranes—for fast relief of colds. NTz is "...singularly effective for nasal congestion due to either allergic or infectious causes."* In a major practice, it has been "an efficient nose drop which has superseded almost all others...."* More than a simple vasoconstrictor, NTz is a combination of three thoroughly evaluated ingredients.

- **N**eo-Synephrine® hydrochloride 0.5 per cent—opens engorged nasal passages, shrinks sinus ostia and provides proper breathing and drainage space.
- **T**henfadil® hydrochloride 0.1 per cent—provides powerful antiallergic action to check rhinorrhea.
- **Z**ephiran® chloride 1:5000 (antibacterial wetting agent and preservative)—promotes spread and penetration to less accessible nasal areas.

NTz is well tolerated by the delicate respiratory tissues. In several hundred patients treated with NTz, there were "...no deleterious effects from...frequent and prolonged use."*

NTz Nasal Spray is also useful in vasomotor (allergic) rhinitis and sinusitis. It is best used twice within five minutes. Supplied in leakproof, pocket-size, squeeze bottles of 20 ml. and in bottles of 30 ml. with dropper.

*Levin, S. J.: **Pediat. Clin. North America** 1:975, Nov., 1954.

NTz, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran chloride (brand of benzalkonium chloride, refined), trademarks reg. U.S. Pat. Off.

Winthrop

WINTHROP LABORATORIES, NEW YORK 18, N.Y.



How to get patients to follow your directions for weight control...easily

60 DELICIOUS FOODS THAT CUT CALORIES, FAT AND CARBOHYDRATES!

How often do you sit across the desk from a patient whose problem is overweight, and wonder whether the directions you give for diet will be followed accurately—or at all?

A pleasant and efficient solution to this problem is to recommend the new Mott's Figure Control Foods. This line of over 60 different items has been developed through the latest scientific knowledge in the field of nutrition—and provides foods lower in calories by an average of 50%. Figure Control Foods take the guesswork out of menu-planning. Calorie cutting can be made pleasant and accurate, while eating normal-size portions of the kinds of food people enjoy every day at breakfast, lunch and dinner.

Low carbohydrate, low fat: Meat products have most of the hard fats removed (these are the saturated type) in a way that cannot be done at home. Sauces and dressings are prepared with a high proportion of non-fat milk solids, vegetable colloids; all are delicious and appetizing. Fruits, juices, desserts and sauces are prepared with non-caloric sweetener—natural fruit values are intact.

The carbohydrate, protein and fat content appears on each label, along with calorie counts. Useful for diabetics, too.

Easy medical tool for doctors: No possible dangerous side effects, not even temporary dislocation of meal patterns. Figure Control Foods in supermarkets include: Soups, Meats, Poultry, Sauces, Salad Dressings, Preserves, Syrup, Fruits, Drinks, Desserts, Sweeteners.

New Mott's Figure Control® Foods offer Good Eating at Half the Usual Calories

	Quantity	Figure Control Calories	"Regular" Food Calories
Apple-Grape Drink	½ cup	20	52
Five-Fruit Juice Breakfast Drink	½ cup	20	52
Braised Beef and Vegetables	6½ oz.	184	380
Meat Balls in Brown Gravy	3½ oz.	84	280
Chopped Chicken Livers	1 oz.	31	100
Chicken a la King	3 oz.	72	230
French Style Dressing	1 tbsp.	10½	60
Brown Gravy	1 tbsp.	7	21

	Quantity	Figure Control Calories	"Regular" Food Calories
Applesauce	½ cup	48	90
Fruit Cocktail	½ cup	44	90
Cherry Pie Filling	1 oz.	20	60
Chocolate Topping	1 tbsp.	8	63
Preserves (Peach, Strawberry)	1 tbsp.	9	55
"Maplette" Syrup	1 tbsp.	9	55
Liquid or Powder Sweetener	(to equal 1 tbsp. of sugar)	0	16



Complete menus, recipes, calorie chart available for professional distribution, with weight control guides you can distribute with confidence: all menus meet N.R.C. Recommended Daily Allowances. **Use this handy order form:**

FIGURE CONTROL FOODS
Duffy-Mott Company
370 Lexington Avenue
New York 17, New York

Please send____free copies of YOUR WEIGHT CONTROL PLAN for use with patients.

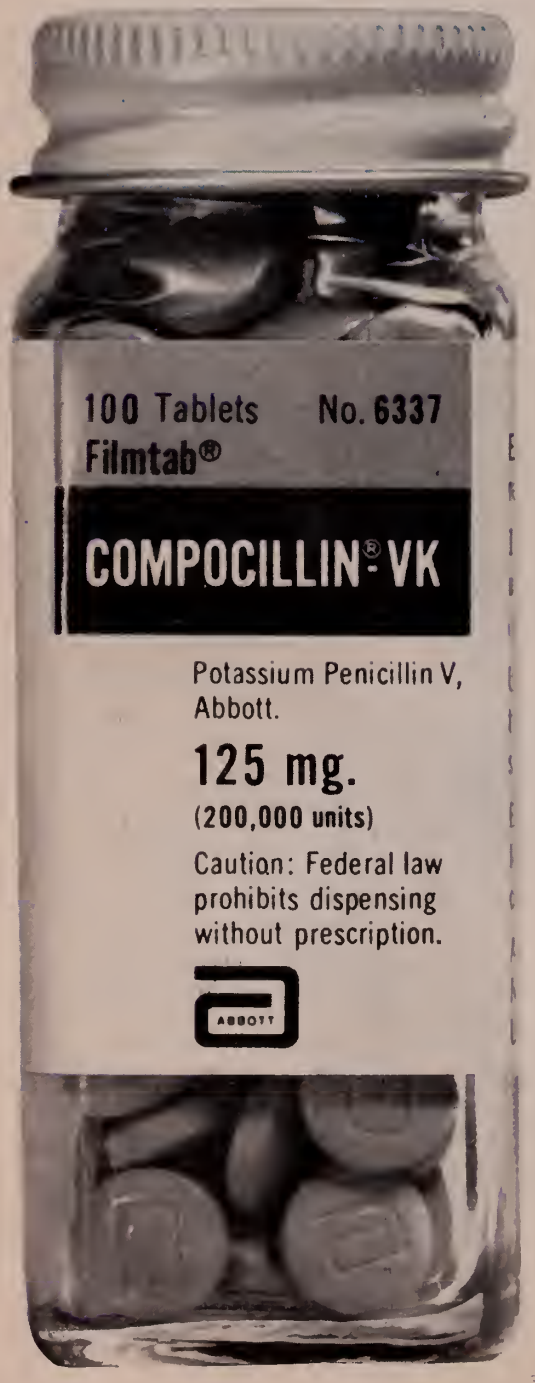
Dr._____

Address:_____

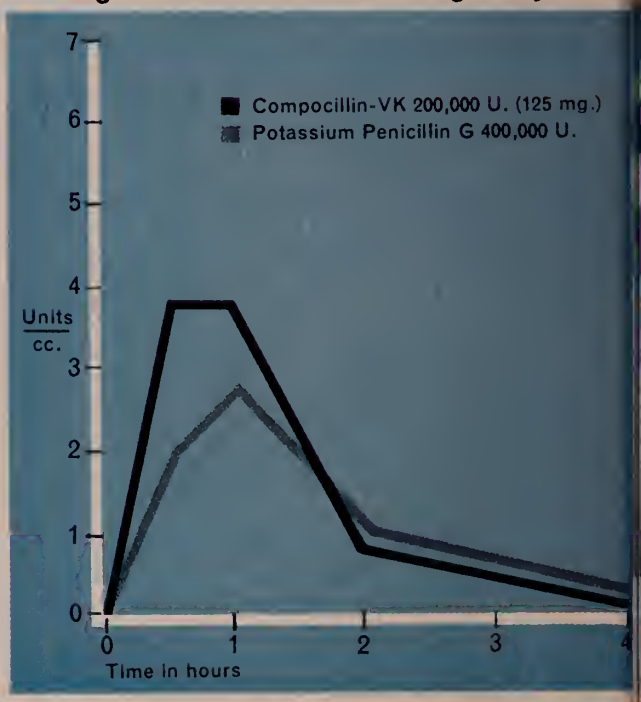
City:_____ Zone:____ State:_____

Here's a penicillin that gives you...

PATIENT ECONOMY WHEN YOU WANT IT



Single Oral Doses to Fasting Subjects*

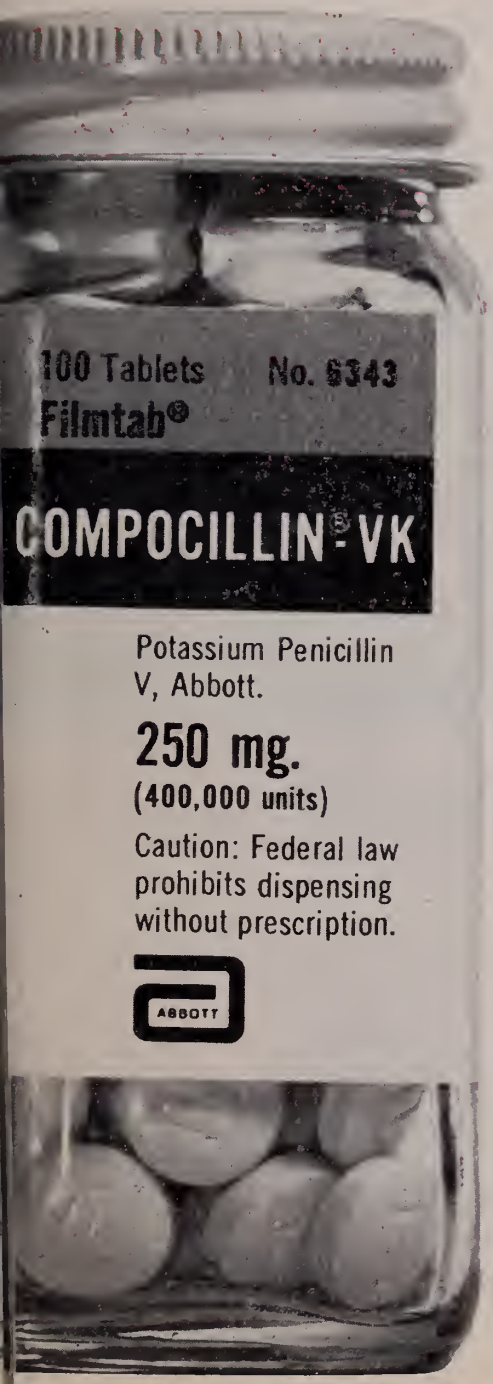


Consider milder bacterial infection

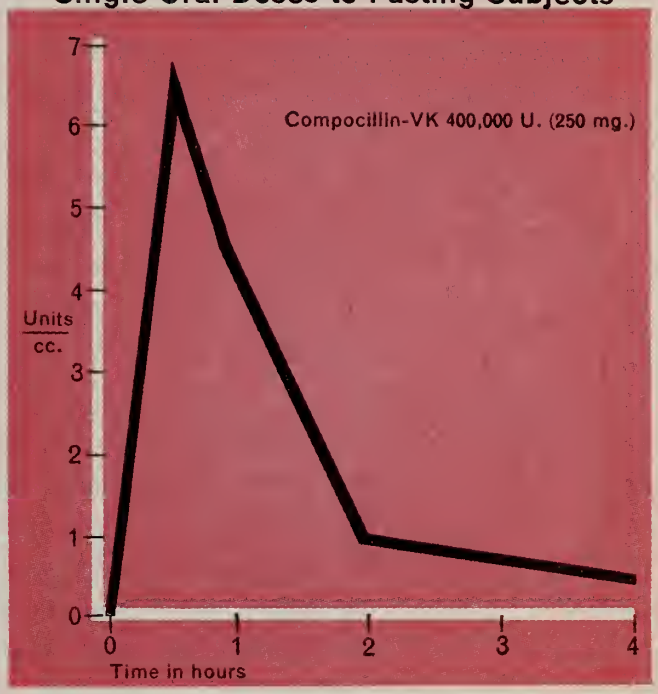
An example might be a respiratory infectio
Here economy could be a definite factor i
your thinking. In the chart above, you'll s
that 200,000 units (125 mg.) of Compocillin V
produces blood levels at least equal to tho
obtained with 400,000 units of oral penicillin
potassium. This means that in less severe infe
tions, Compocillin-VK may be given at *half* t
dosage needed with oral penicillin G—with
sacrifice in blood levels. In these cases, the co
of Compocillin-VK therapy will be no more-
and often will be less—than treatment with or
penicillin G.

Compocillin-VK—the original potassium penicillin V • In Filmt
(125 and 250 mg.) and cherry-flavored Granules for Oral Suspens
Filmtab—Film-sealed tablets, Abbott: U.S. Pat. No. 2,881,085

PEAK EFFICIENCY WHEN YOU NEED IT



Single Oral Doses to Fasting Subjects*



Then, for severe infections...

. . . where your primary concern is high peak serum concentrations, you can prescribe Compocillin-VK at *full therapeutic dosage* and get the maximum antibacterial activity possible with an oral penicillin. The chart above shows the rapid peak blood levels obtained with 400,000 units (250 mg.) of Compocillin-VK. Actually, these peaks occur faster—and are higher—than those obtained with intramuscular penicillin G. Indeed, Compocillin-VK has been used in cases previously reserved for parenteral treatment. The safety advantage (oral vs. injectable) goes without saying.

*Chart data from two separate studies completed by the Microbiologic and Medical Departments of Abbott Laboratories.

ABBOTT LABORATORIES NORTH CHICAGO, ILLINOIS

Trocinate®

Brand of Thiphenamil HCl.

FOR DIVERTICULITIS, MUCUS COLITIS,

IRRITATIVE DIARRHEA, IRRITATIVE URETERITIS,

BLADDER SPASM

*T*rocinate is a musculotropic antispasmodic with no appreciable anticholinergic action. It relieves spasms of the lower bowel and genito-urinary tract by direct action on the contractile mechanism of smooth muscles. The absence of any appreciable action on the autonomic nervous system eliminates the usual side-effects. It may be safely used in glaucoma. Each tablet contains 100 mgs. Trocinate HCl.

USUAL DOSAGE: 2 tablets, 4 times a day. Maintenance dosage is frequently lower.

Dispensed in bottles of 40 and 250 tablets.

WM. P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856

indication:
acute respiratory inflammation



Bronchial Inflammation

indicated:

Chymoral®

ORAL systemic anti-inflammatory enzyme tablet

80% Excellent/Good Results in 4,491 patients[1-4]

By subduing the inflammatory reaction of respiratory tract tissues, Chymoral liquefies thickened bronchial secretions and affords easier expectoration of mucus plugs. In a series of 48 patients with bronchial asthma, 44 were afforded good to excellent relief with Chymoral therapy.[1] In chronic obstructive emphysema, Chymoral improves both vital capacity and the ability to expectorate without severe, racking cough effort.[2] And in sinusitis or rhinitis there is a definite reduction of inflammation and edema of the nasal and sinal mucosa, along with improved airflow.[2-3]

controls inflammation, curtails swelling, relieves pain

1. Taub, S. J.: Clin. Med. 7:2575, 1960. 2. Clinical Reports to the Medical Department, Armour Pharmaceutical Company, 1960. 3. Billow, B. W., *et al.:* Southwestern Med. *41*:286, 1960. 4. Physicians' Reports to the Medical Department, Armour Pharmaceutical Company, 1961.

CHYMORAL is an ORAL anti-inflammatory enzyme tablet specifically formulated for intestinal absorption. Each tablet provides enzymatic activity, equivalent to 50,000 Armour Units, supplied by a purified concentrate which has specific trypsin and chymotrypsin activity in a ratio of approximately six to one. ACTION: Reduces inflammation of all types; reduces and prevents edema except that of cardiac or renal origin; hastens absorption of blood and lymph extravasates; helps to liquefy thick tenacious mucous secretions; improves regional circulation; promotes healing; reduces pain. INDICATIONS: Chymoral is indicated in respiratory conditions such as asthma, bronchitis, rhinitis, sinusitis; in accidental trauma to speed absorption of hematoma, bruises, and contusions; in inflammatory dermatoses to ameliorate acute inflammation in conjunction with standard therapies; in gynecologic conditions such as pelvic inflammatory disease and mastitis; in obstetrics as episiotomies and breast engorgement; in surgical procedures as biopsies, hernia repairs, hemorrhoidectomies, mammectomies, phlebitis and thrombophlebitis; in genitourinary disorders as epididymitis, orchitis and prostatitis; in dental and oral surgery as fractures of the mandible or maxilla, difficult or multiple extractions, and alveolectomies. CONTRAINDICATIONS: None known. INCOMPATIBILITIES: None known. Antibiotics as well as generally accepted measures may be coadministered. SIDE EFFECTS: Mild gastric upsets, rarely encountered. DOSAGE: Recommended initial dose is two tablets q.i.d.; one tablet q.i.d. for maintenance. SUPPLIED: Bottles of 48 and 250 tablets. Issue: Rev. Jan., 1963

The true economy of proven effective dosage

ARMOUR PHARMACEUTICAL COMPANY
KANKAKEE, ILLINOIS
Originators of Listica®



BENEFICIAL RESULTS were obtained with **SARDO** in the bath in 122 of 135 patients (90%) with dry, itchy skin conditions, in most cases with beneficial effect "after the first bath." Dryness was allayed in all cases, and associated itching "either completely relieved or greatly improved." No irritation or sensitization was observed.

This new study corroborated others[2-4] showing that SARDO helps re-establish the normal physiologic lipid-aqueous skin balance.

Pleasant, easy-to-use SARDO releases millions of microfine water-dispersible globules* in the bath. Bottles of 4, 8 and 16 oz.

*Patent Pending T.M. (c) 1963 by Sardeau, Inc.

SAMPLES and literature available from . . .

SARDEAU, INC.

75 East 55th Street, New York 22, N. Y.

1. Borota, A., and Grinell, R. N.: J. Amer. Geriatrics Soc., 10:413, 1962.
2. Spoor, H. J.: N. Y. State J. M. 58:3292, 1958.
3. Lubowe, I. I.: Western Med. 1:45, 1960.
4. Weissberg, G.: Clin. Med. 7:1161, 1960.


who coughed?
HYCOMINE®
SYRUP
for COUGHS
provides fast and long-lasting cough control
relieves cough in 15-20 minutes • lasts 6 hours or longer • promotes expectoration and decongestion of air passages • rarely constipates • agreeably cherry-flavored
Each teaspoonful (5 cc.) of HYCOMINE Syrup contains:
Hycodan® ..... 6.5 mg.
Dihydrocodeinone Bitartrate .... 5 mg.
(Warning: May be habit-forming)
Homatropine Methylbromide ... 1.5 mg.
Pyrilamine Maleate ..... 12.5 mg.
Phenylephrine Hydrochloride ..... 10 mg.
Ammonium Chloride ..... 60 mg.
Sodium Citrate ..... 85 mg.
Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. On oral prescription where state laws permit. U.S. Pat. 2,630,400.
Literature on request
Endo®
ENDO LABORATORIES
Richmond Hill 18, New York



excessive uterine bleeding*

"significant improvement..."[1]

duo-CVP®

(double-strength CVP)

In patients in whom there was "flooding" (associated with menorrhagia for which no organic cause could be isolated), non-hormonal therapy with duo-C.V.P. achieved "excellent" results as assessed by easy control of bleeding, improved sense of well-being, and ability to maintain normal activities. "In no case has there been any instance of side effects."[1]

The clinician attributes the anti-hemorrhagic effects of duo-C.V.P. to its apparent ability to restore normal small vessel structural integrity and function.

duo-C.V.P. and C.V.P.† have also been reported of value in the treatment of capillary bleeding associated with other gynecologic conditions such as threatened and habitual abortion, post-partum bleeding and functional menometrorrhagia.[2-5]

Each duo-C.V.P. capsule provides:	
CITRUS BIOFLAVONOID COMPOUND	200 mg.
ASCORBIC ACID (VITAMIN C)	200 mg.

Bottles of 50, 100, 500 and 1000 capsules.

†C.V.P. provides in each capsule 100 mg. of an exclusive citrus bioflavonoid compound and 100 mg. of ascorbic acid. Bottles of 100, 500 and 1000 capsules.

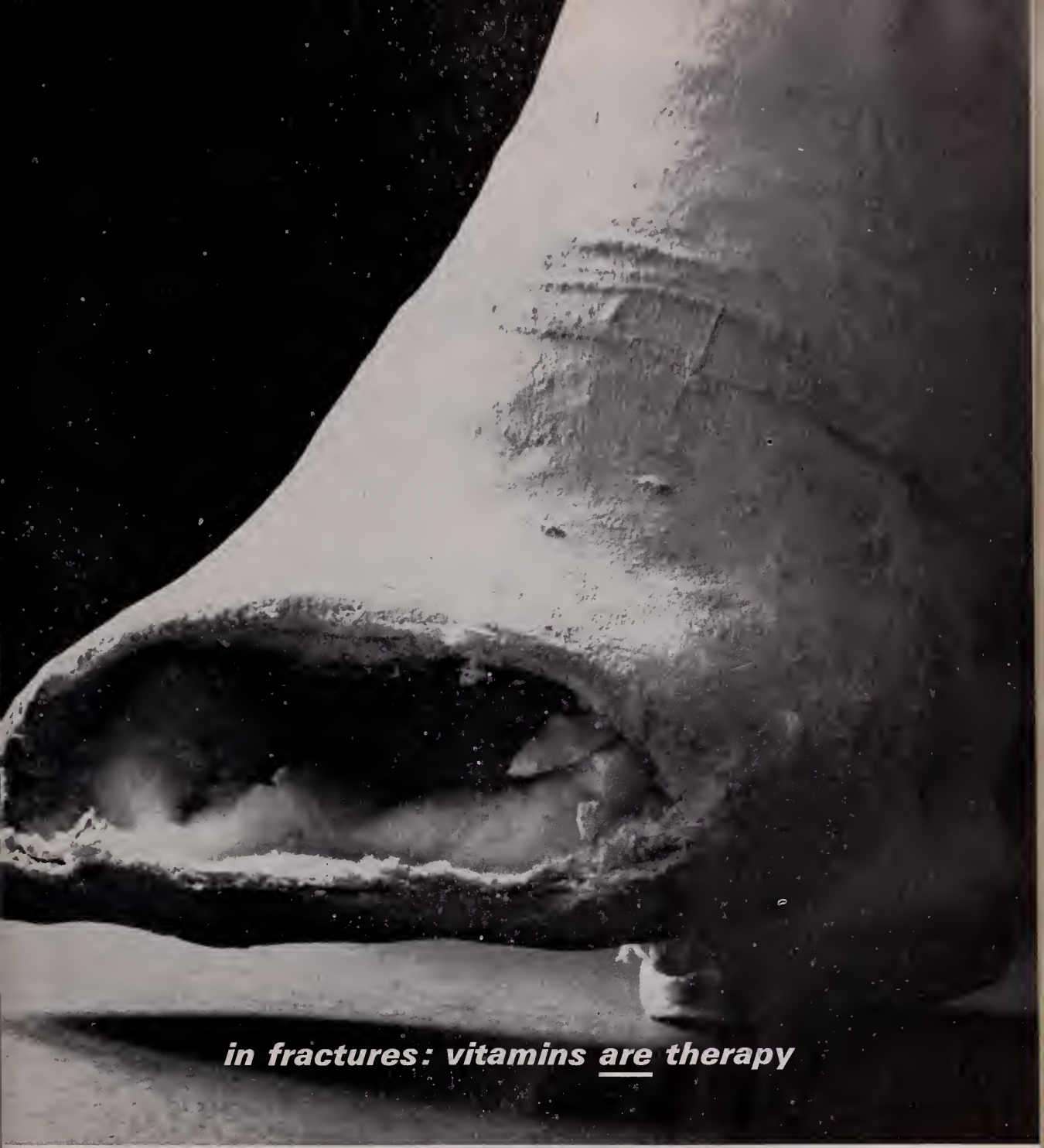
references: 1. Prueter, G. W.: Applied Therapeutics 3:351, 1961. 2. Taylor, F. A.: West J. Surg., Obstet. & Gynec. 64:280, 1956. 3. Ainslie, W. H.: Obstet. & Gynec. 13:185, 1959. 4. Pearse, H. A. and Trisler, J. D.: Clin. Med. 4:1081, 1957. 5. Clemetson, C. A. B. and Blair, L. M.: Am. J. Obst. & Gynec. 83:1269, 1962.

menorrhagia*

Samples and literature from

u. s. vitamin & pharmaceutical corp.

Arlington-Funk Laboratories, division • New York 17, N. Y.



ew factors are more fundamental to tissue and bone ealing than nutrition. Therapeutic allowances of B and C itamins are important for rapid replenishment of vitamin eserves which may be depleted by the stress of fractures. Metabolic support with STRESSCAPS is a useful adjunct o an uneventful recovery. Supplied in decorative reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

EDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

STRESSCAPS®

SPECIAL COUGH FORMULA
for Children

Pediacof®

SOOTHING DECONGESTANT AND EXPECTORANT

Each teaspoon (5 ml.) contains:

Codeine phosphate	5.0 mg.
Neo-Synephrine® hydrochloride (brand of phenylephrine hydrochloride)	2.5 mg.
Chlorpheniramine maleate	0.75 mg.
Potassium iodide	75.0 mg.



Bright red, pleasant tasting, raspberry flavored syrup

Dosage:

Children from 6 months to 1 year, 1/4 teaspoon; 1 to 3 years, 1/2 to 1 teaspoon; 3 to 6 years, 1 to 2 teaspoons; 6 to 12 years, 2 teaspoons. Every four to six hours as needed.

How Supplied:
Bottles of 16 fl. oz.

Available on prescription only.

Exempt Narcotic

Winthrop
LABORATORIES
New York 18, N. Y.

what your patients need to know about Aspirin



As you know, the confidence your patients place in a certain treatment or drug often helps to reinforce the relief they get from it. That's why it's often a good idea to explain the reasons for your recommendations, even in the simplest cases.

For example, aspirin. You probably recommend it more than any other drug, as an analgesic, as an antipyretic, as an aid to sleep when restlessness is caused by minor discomforts. Certainly aspirin is the most versatile and one of the most effective drugs in the arsenal of medicine.

But aspirin is such a common and such a safe drug that most laymen vastly underrate it. To use it with the utmost confidence, they need to know more about it. So next time, take a minute or two to explain what a uniquely valuable drug aspirin really is. You know it; your patients will be reassured to know it, too.

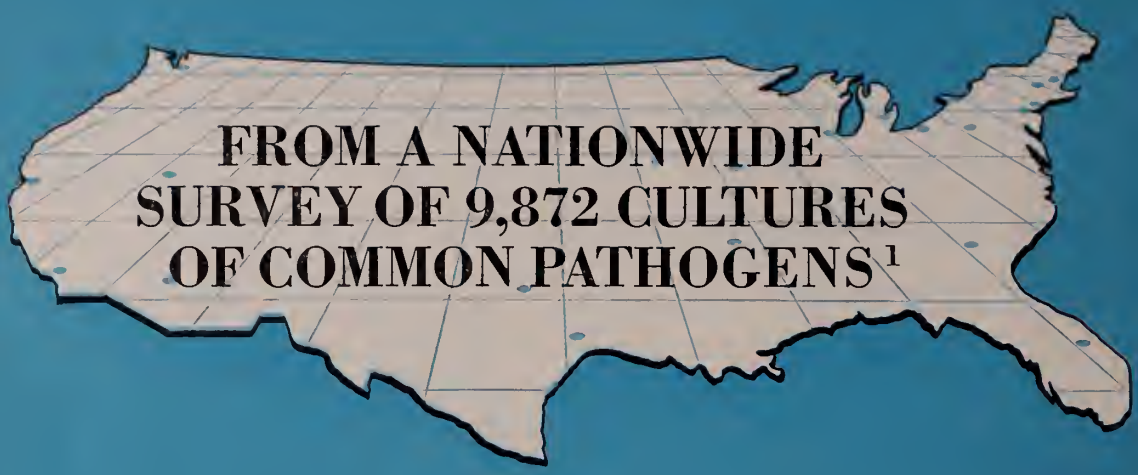
5-grain tablets



1¼-grain tablets



For professional samples,
write The Bayer Company,
1450 Broadway,
New York 18, N. Y.



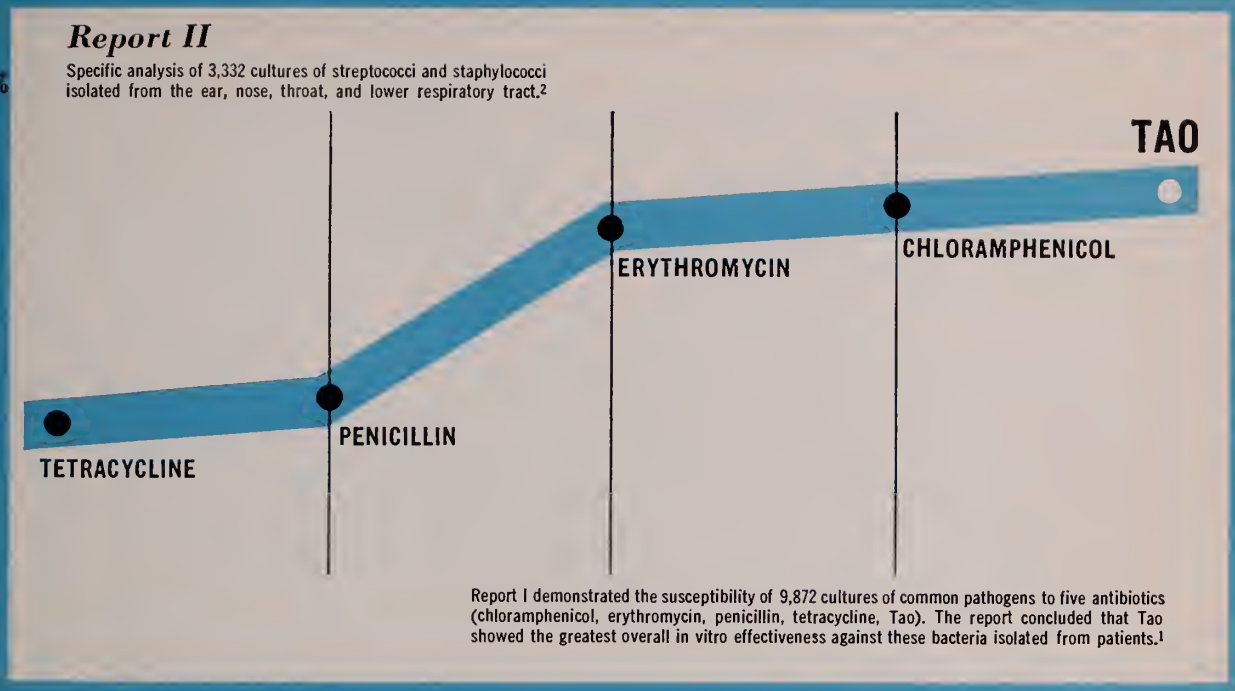
FROM A NATIONWIDE SURVEY OF 9,872 CULTURES OF COMMON PATHOGENS[1]

Conclusions of Nationwide Survey: *Report I*

1. **Even after five years of general use,** Tao, of the antibiotics tested, demonstrated greatest activity against respiratory streptococci and staphylococci (3,332 cultures).

2. **Overall results showed a higher percentage of susceptibility** among these common pathogens to Tao than to the other antibiotics. Susceptibility to Tao was greatest, not only in respiratory streptococci and staphylococci, but also in these organisms isolated from skin and soft tissue (3,423 cultures), genitourinary and gastrointestinal tracts and other sources (2,458 cultures). Susceptibility was equal to all antibiotics tested in pneumococci from unspecified sources (463 cultures), and less to Tao in H. influenzae from unspecified sources (196 cultures).

3. **Tao has been used for five years without development of predictable cross resistance.** In 1958 and 1961, approximately 73% and 70%, respectively, of erythromycin-resistant problem staphylococci showed susceptibility to Tao.[3,4] The present study confirms the continuing high degree of Tao activity even against these pathogens. Of 1,592 cultures of erythromycin-resistant staphylococci, 68% were susceptible to Tao, while in the reverse situation, only 33% of 768 Tao-resistant staphylococci were susceptible to erythromycin.



Report II

Results of Bacterial Susceptibility in 3,332 Respiratory Pathogens

References

1. "Bacterial Susceptibility Patterns: A Geographic Survey." Fowler, J. Ralph, M.D., and Watters, John L., M.D. Scientific Exhibit presented at the Annual Meeting of the American Society of Clinical Pathologists, Chicago, Ill., August 31 to September 9, 1962. 2. Fowler, J. Ralph, Watters, John L. and Levy, Arthur M.: Bacterial Susceptibility Patterns as Related to Geographic Variation and Anatomical Source. In press. 3. English, A. R., and Fink, F. C.: Antibiot. & Chemother. 8:420 (Aug.) 1958. 4. English, A. R., and Fink, F. C.: Antibiot. and Chemother. 11:648 (Oct.) 1961.

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being®

If you would like a report of the entire susceptibility study, write Medical Department, J. B. Roerig and Company, 235 E. 42nd St., New York 17, N.Y.



Capsules · Ready-Mixed Oral Suspension · Pediatric Drops · Parenteral (as oleandomycin phosphate)

THE MEDICAL SOCIETY OF NEW JERSEY

ENDORSED PLANS OF

Accident and Health Insurance
Major Medical Expense Insurance
Term Life Insurance

* * *

Up to $1,200 monthly benefit for loss of time due to accident or sickness.

Applications for initial coverage and increased benefits considered at all times.*

$10,000 major medical expense insurance for each accident or sickness, covering member, spouse and eligible children. Pays 80% of covered expenses after a $500 deductible.

Applications considered at all times.*

Up to $50,000 Term Life Insurance

Applications for initial $10,000 policy and additional $10,000 policies up to $50,000 total under this plan considered during the month of November each year.*

*New members have special privileges during first few months of membership; ask for specific details if you were recently elected and have not received notifications from us. All applications subject to company rules and regulations for acceptance of risks.

* * *

FOR FULL DETAILS ON ANY PLAN CONTACT:

E. & W. BLANKSTEEN
E. & W. Blanksteen Agency, Inc.

75 Montgomery Street *Jersey City 2, New Jersey*

DElaware 3-4340



The good life–just what the doctor ordered

and sun are both in his doctor's or- — so is that grapefruit he's eating such gusto. Citrus fruit is a wonder- ay for this patient or any patient to is daily quota of vitamin C . . . to something good to eat, tasty and ying but not rich.

ot all patients are so lucky as to retired to Florida, where they can each out to pick citrus fruit off their orange and grapefruit trees. But any nt anywhere can get the same benefits of the natural vitamin C in Florida oranges, grapefruit, and tangerines . . . thanks to modern methods of processing fresh fruit. Whether it is frozen, canned, or in cartons, 98% of the vitamin C content of the fruit is preserved.

Grapefruit and other citrus fruits filled with vitamin C are valuable in the nutrition of every age group. Among the teen-agers, vitamin C is one of the two nutrients most often low in the diet. Infants, too, need generous amounts of vitamin C; and they will take it readily when it comes to them in the form of delicious orange juice.

When your patient chooses *Florida* citrus, he can be sure of getting fruit filled with natural goodness and of just the right sweetness. Florida citrus is unexcelled because a State commission watches over the entire Florida citrus crop to see that it meets the world's highest standards for fresh, frozen, canned, or cartoned citrus fruits or juices.

© Florida Citrus Commission, Lakeland, Florida



For peptic ulcer gastric hyperacidity and gastritis...

In year-long study on peptic-ulcer patients

New Creamalin®
Antacid Tablets

*"...faster in onset of action...and for a longer period"**

"Clinical studies in 85 patients with duodenal ulcer ...confirmed the superiority of the new preparation [new Creamalin] over standard aluminum hydroxide preparations, in that prompt relief was achieved and maintained throughout the period of observation."*

Patients were followed for about one year.

New Creamalin promotes ulcer healing, permits less frequent feedings because it is so long-acting. Heartburn and epigastric distress were "...easily and adequately controlled...."* New Creamalin has the therapeutic advantage of a liquid antacid with the convenience of a palatable tablet. *It does not cause constipation.*

Each new Creamalin tablet contains 320 mg. of specially processed highly reactive dried aluminum gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles offer a vastly increased surface area.

Dosage: Gastric hyperacidity—from 2 to 4 tablets as needed. Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours. *How Supplied:* Bottles of 50, 100, 200 and 1000.

Now also available—New Creamalin Improved Formula Liquid. Pleasant mint flavor—creamy pink color. Stabilized reactive aluminum and magnesium hydroxide gel (1 teaspoon equals 1 tablet). Bottles of 8 and 16 fl. oz.

Creamalin, trademark reg. U.S. Pat. Off

*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961.

Winthrop LABORATORIES New York 18, N. Y.



Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. USUAL DOSAGE: 1 TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey



When treatment for

IMPOTENCE

is indicated

ANDROID™ tablets

ANDROGEN-THYROID-COMBINATION

in two convenient dosage forms

ANDROID	ANDROID-H.P. (High Potency)
Each yellow tablet contains:	Each orange tablet contains:
Methyl Testosterone ....2.5 mg.	Methyl Testosterone .....5 mg.
Thyroid Ext. (1/6 gr.) ....10 mg.	Thyroid Ext. (1/2 gr.) ....30 mg.
Glutamic Acid .....50 mg.	Glutamic Acid .....50 mg.
Thiamine HCl .....10 mg.	Thiamine HCl .....10 mg.

INDICATIONS: **Impotence in male.**

AVERAGE DOSE: One tablet three times daily.

AVAILABLE: Bottles of 100 and 500 at your pharmacy.

CAUTION: Not to be used when testosterone is contra-indicated. Federal law prohibits dispensing without prescription.

1. *Methyltestosterone-Thyroid in Treating Impotence*, A. S. Titeff, *General Practice, Vol. 25, No. 2, February, 1962, pp. 6-8.*
2. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism, August 1959.*

Write for samples and literature...

BROWN **THE BROWN PHARMACEUTICAL COMPANY**

2500 West Sixth Street, Los Angeles 57, California



CHELATION — (GR-CHELE: CLAW OR TO HOLD.)

The FIRST Hematinic to Contain BOTH CHELATED IRON and CHELATED MINERALS Assuring a Truly Flavorful, Better Tolerated Iron Therapy.

KELATRATE

LIQUID HEMATINIC

CHELATED IRON-MINERALS and VITAMINS

ADVANTAGES —

Chelated Iron PLUS 4 Chelated Minerals • High Therapeutic Effectiveness • Less Irritation — even on empty stomach • No Tooth Stain • Less Toxic • B-Vitamins for Added Hemopoietic Activity • Pleasant Flavor • Economical

FORMULA —

Each 5 cc. (one teaspoonful) contains:

Iron (as Ferrous Betaine Citrate)	30 mg.
Cobalt (as Cobaltous Betaine Citrate)	0.1 mg.
Manganese (as Manganese Betaine Citrate)	1.0 mg.
Zinc (as Zinc Betaine Citrate)	1.25 mg.
Magnesium (as Magnesium Betaine Citrate)	6.0 mg.
Vitamin B-1	1.5 mg.
Vitamin B-2	1.2 mg.
Vitamin B-12	6.0 mcg.
Niacinamide	10 mg.
Panthenol	10 mg.

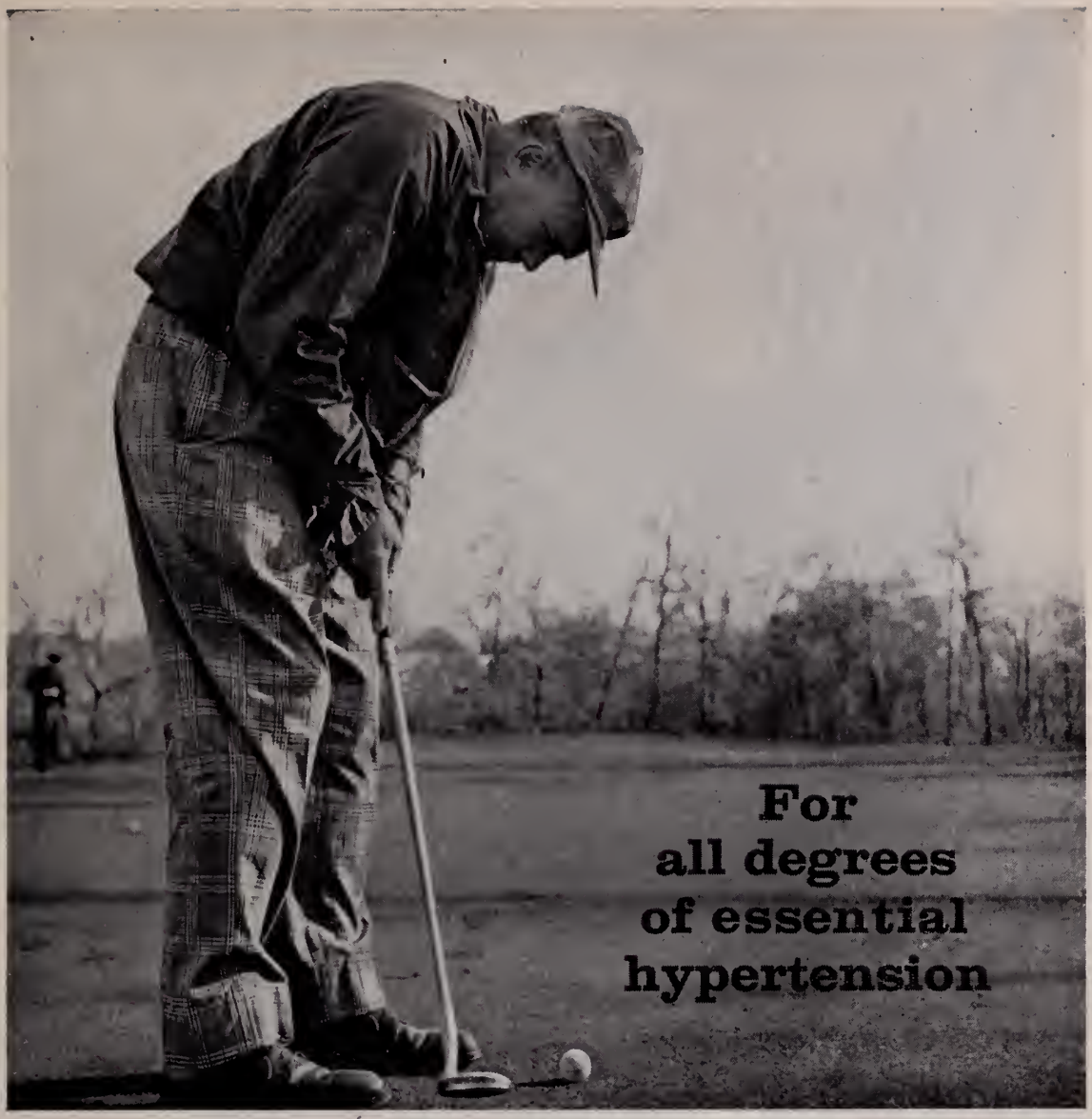
In an exceptionally pleasant tasting base.

Comprehensive literature and samples on request.

S. J. TUTAG & CO.

DETROIT 34, MICHIGAN

TUTAG



"relief of symptoms is striking with Rautrax-N"†

Rautrax-N decreases blood pressure for almost all patients with mild, moderate or severe essential hypertension. Rautrax-N also offers a new sense of relaxation and well-being in hypertension complicated by anxiety and tension. And in essential hypertension with edema and/or congestive heart failure, Rautrax-N achieves diuresis of sodium and chloride with minimal effects on potassium and other electrolytes.

Rautrax-N combines Raudixin (antihypertensive-tranquilizer) with Naturetin c̄ K (antihypertensive-diuretic) for greater antihypertensive effect and greater effectiveness in relief of hypertensive symptoms than produced by either component alone. Rautrax-N is also flexible (may be prescribed in place of Raudixin or Naturetin c̄ K) and economical (only 1 or 2 tablets for maintenance in most patients).

Supply: Rautrax-N — capsule-shaped tablets providing 50 mg. Raudixin, 4 mg. Naturetin and 400 mg. potassium chloride. *Rautrax-N Modified* — capsule-shaped tablets providing 50 mg. Raudixin, 2 mg. Naturetin and 400 mg. potassium chloride.

†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

For full information, see your Squibb Product Reference or Product Brief.

Rautrax-N*

Squibb Standardized Rauwolfia Serpentina Whole Root (Raudixin) and Bendroflumethiazide (*Naturetin) with Potassium Chloride

SQUIBB *Squibb Quality — the Priceless Ingredient*

SQUIBB DIVISION Olin

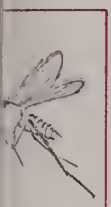
'RAUDIXIN'®, 'RAUTRAX'®, AND 'NATURETIN'® ARE SQUIBB TRADEMARKS.

from Oroya fever in Peru

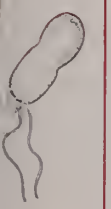


lobar pneumonia in New Jersey

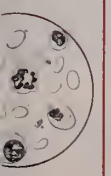
is a world of experience behind BRAND OF OXYTETRACYCLINE Terramycin®



Whether treating Oroya fever or a host of other infections, physicians throughout the world continue to rely on TERRAMYCIN for its outstanding safety, effectiveness and excellent tolerability. Not a single case of phototoxic reaction, blood dyscrasia or neurologic disturbance directly attributable to TERRAMYCIN has been reported in more than 3,000 clinical papers in the last 12 years. *In your practice, the next infection you see will very likely be "Terra-responsive."*



Oroya fever (Carrión's disease), prevalent only in certain valleys of the Andes, is characterized by a rapidly evolving, febrile pernicious anemia. The infecting organism is *Bartonella bacilliformis,* a gram-negative, flagellated organism, transmitted by night bites of the phlebotomus, or sand fly. The organism is unmistakably identifiable in blood films—no other human pathogen even slightly resembles it. The mortality rate of untreated Oroya fever can be as high as 40 per cent (in all probability, this was the disease which decimated Pizarro's army in the 16th century). Treatment with Terramycin produces dramatic reduction of fever and a stabilized blood count in 48 hours or less.



IN BRIEF The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. For complete information on Terramycin dosage, administration, and precautions, consult package insert before using. *More detailed professional information available on request.*

Science for the world's well-being®

Pfizer

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc.
New York 17, New York



RADON • RADIUM

SEEDS • IMPLANTERS • CERVICAL APPLICATORS

THE RADIUM EMANATION CORPORATION

GRAYBAR BUILDING • NEW YORK 17, N. Y.

Wire or Phone MUrray Hill 3-8636 Collect

THE NINTH HAHNEMANN SYMPOSIUM

Theory and Practice of Auscultation

April 15, 16, 17 at the Sheraton Hotel Philadelphia, Pennsylvania

Physics, registration, recognition and diagnosis of heart sounds and murmurs in congenital, rheumatic and coronary heart disease. Case presentations. Bedside diagnosis. Tape recordings. Individual audiophones. New technics. Limited to 1,000.

Bernard Segal, M.D., Symposium Director

HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, 230 NORTH BROAD ST., PHILA. 2, PA.

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

March 4, 5, 6 and 7 ,1963

Palmer House, Chicago

Daily Half-Hour Lectures by Outstanding Teachers and Speakers on subjects of interest to both general practitioner and specialist.

Panels on Timely Topics
Medical Color Telecasts
Teaching Demonstrations
Instructional Courses
Film Lectures

Scientific Exhibits worthy of real study and helpful and time-saving Technical Exhibits.

The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.



Relieves Anxiety and Anxious Depression

e outstanding effectiveness and record of safety with which ltown relieves anxiety and anxious depression—the type of pression in which either tension or nervousness or insomnia a prominent symptom — has been clinically authenticated ne and again during the past seven years. This, undoubtly, is one reason why physicians still prescribe meprobamate re often than any other tranquilizer in the world.

Miltown®

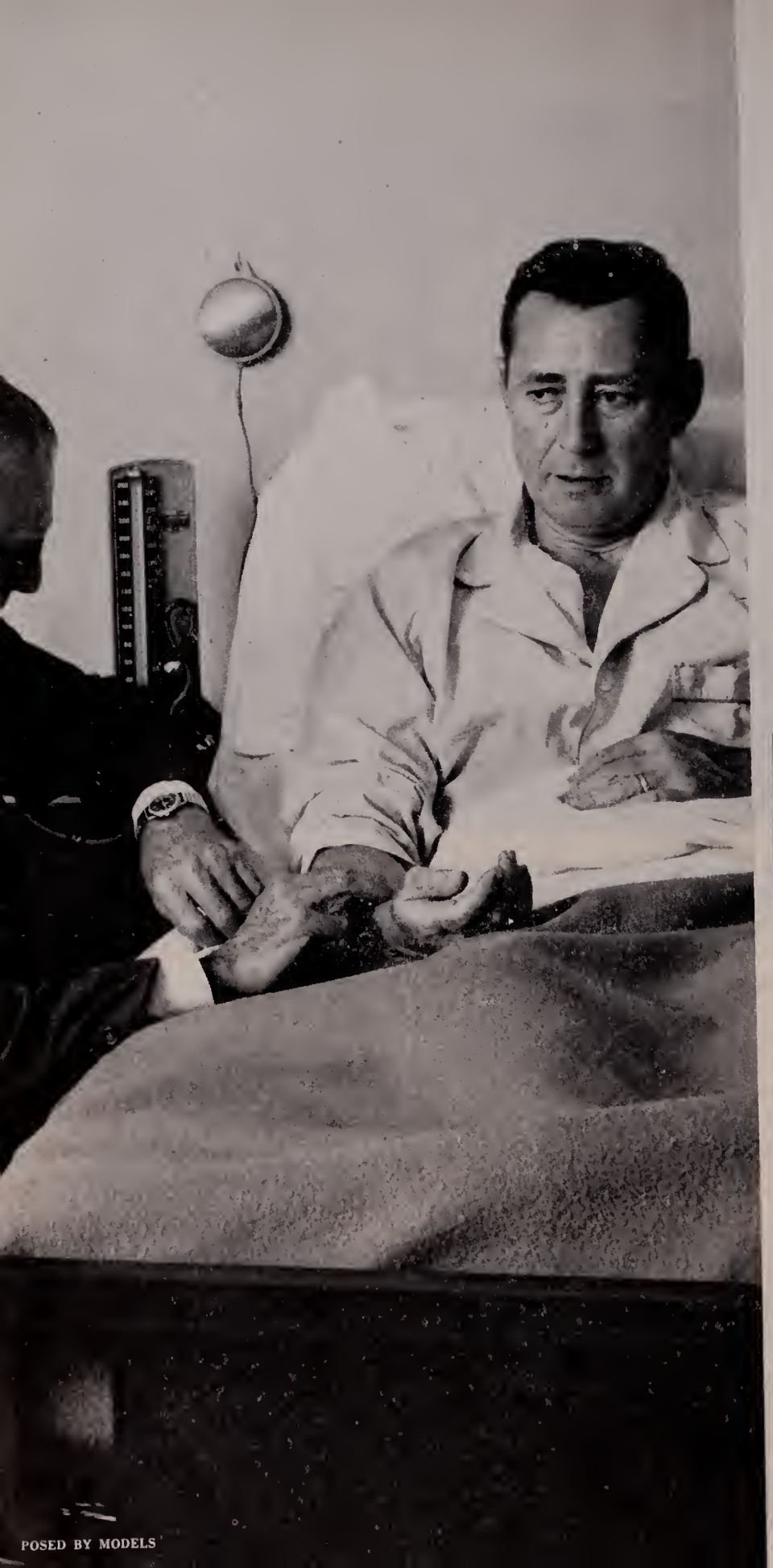
meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS® — 400 mg. *unmarked*, coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

WALLACE LABORATORIES / *Cranbury, N. J.*

Clinically proven in over 750 published studies

1. Acts dependably — without causing ataxia or altering sexual function
2. Does not produce Parkinson-like symptoms or liver damage
3. Does not muddle the mind or impair physical activity



POSED BY MODELS

all things considered

in bronchitis—Considering the pattern of mixed bacteria, localized or diffus involvement, potential underlying disease, and the need to allay symptoms and eas respiratory/cardiac function... physicians often include DECLOMYCIN demethylchlor tetracycline in the course of therapy.

DECLOMYCIN produces activity levels higher than those of other tetracyclines... at lowe dosage... and maintains them during the entire course of treatment without significan fluctuation.

This activity is prolonged 24 to 48 hours after the last dose, helping to protect against relapse

Over the wide range of everyday infections—respiratory, urinary and most others—in th young and the aged—the acutely or chronically afflicted—DECLOMYCIN provides th "extra dimension" in broad spectrum control.

the decision is for

For *adults: Capsules*, 150 mg. and 75 mg. For *children:* cherry-flavored *Pediatric Drops*, 60 mg./cc., and cherry-flavore *Syrup*, 75 mg./5 cc. Request complete information on indications, dosage, precautions and contraindications from you Lederle representative, or write to Medical Advisory Department.

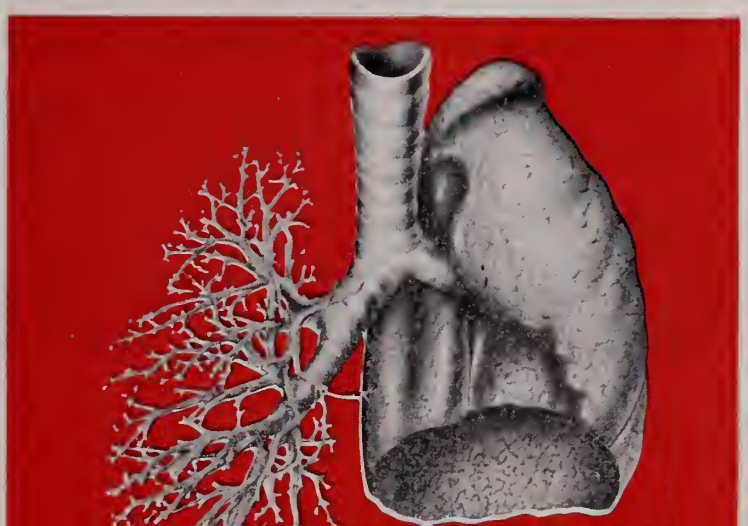
ECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY • Pearl River, N. Y. Lederle









neither **stasis** nor **spasm,**
nor **tension**
stays this patient
from his
appointed rounds



DECHOLIN-BB®

. . . . . especially when
UPPER G.I. COMPLAINTS
have biliary implications

Each Tablet Contains:

for biliary/intestinal **stasis** → DEHYDROCHOLIC ACID 250 mg. (3¾ gr.)

for smooth-muscle **spasm** → BELLADONNA EXTRACT 10 mg. (⅙ gr.)

for nervous **tension** → BUTABARBITAL SODIUM 15 mg. (¼ gr.)

Average adult dose: 1 or, if necessary, 2 tablets three times daily. **Precautions:** Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction; caution drivers against possible drowsiness. **Side effects:** Dehydrocholic acid may cause transitory diarrhea; belladonna may cause blurred vision and dry mouth. **Contraindications:** Biliary tract obstruction, acute hepatitis, glaucoma, prostatic hypertrophy. **Available:** DECHOLIN-BB, bottles of 100 tablets. **Also:** DECHOLIN® with Belladonna (dehydrocholic acid, 250 mg.; belladonna extract, 10 mg.) and DECHOLIN® (dehydrocholic acid, 250 mg.), bottles of 100 and 500 tablets.

AMES
COMPANY, INC.

asthma attack averted
. . . in minutes

patient protected
. . . for hours





Nephenalin®

(the dual-action anti-asthmatic tablet)

. . . works with nebulizer speed—provides four-hour protection

One NEPHENALIN tablet provides: *air in a hurry*—through sublingual isoproterenol HCl, 10 mg. *air for hours*—through theophylline, 2 gr.; ephedrine, 3/8 gr.; phenobarbital, 1/8 gr.

Dosage: Hold one NEPHENALIN tablet under the tongue for five minutes to abort the asthmatic attack promptly. Then swallow the tablet core for four full hours' protection against further attack. Only one tablet should be taken every four hours. No more than five tablets in 24 hours.

Supplied: Bottles of 50 tablets. For children: NEPHENALIN Pediatric, bottles of 50 tablets.

Caution: Do not administer NEPHENALIN with epinephrine. The two medications may be alternated at 4-hour intervals. NEPHENALIN should be administered with caution to patients with hyperthyroidism, acute coronary disease, cardiac asthma, limited cardiac reserve, acute myocardial damage, and to those hypersensitive to sympathomimetic amines. Phenobarbital may be habit forming. THOS. LEEMING & CO., INC., New York 17, N.Y.

Since the influenza epidemic of 1918

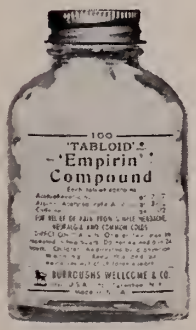


....the first choice of many physicians to relieve aches, pains, fever, and general malaise of colds and flu.

Symptomatic and supportive treatment of patients with upper respiratory infections still consists largely of rest, analgesics, fluids and nasal decongestants. During the fateful influenza epidemic of 1918, 'Empirin' Compound was widely used and became well known as a well tolerated and reliable analgesic combination. It was one of the few available analgesic products effective in simultaneously reducing fever and relieving the general malaise which often accompany the flu.

Later, 'Empirin' Compound with Codeine took its place with the widely used 'Empirin' Compound, as a product useful when increased analgesia or antitussive action was desired. Today, 'Empirin' Compound with Codeine is one of the most widely prescribed drugs in medicine, providing physicians with a dependable analgesic, especially useful in relieving the symptoms of colds and flu. We believe you will also find 'Empirin' Compound with Codeine Phosphate gr. ¼ (16 mg.) or gr. ½ (32 mg.) particularly useful in treating the troublesome cough that is often part of the influenza symptom complex.

'EMPIRIN' COMPOUND with CODEINE PHOSPHATE *



gr. ⅛ gr. ¼ gr. ½ gr. 1



* Available on oral prescription where State law permits. Subject to Federal Narcotic Regulations.

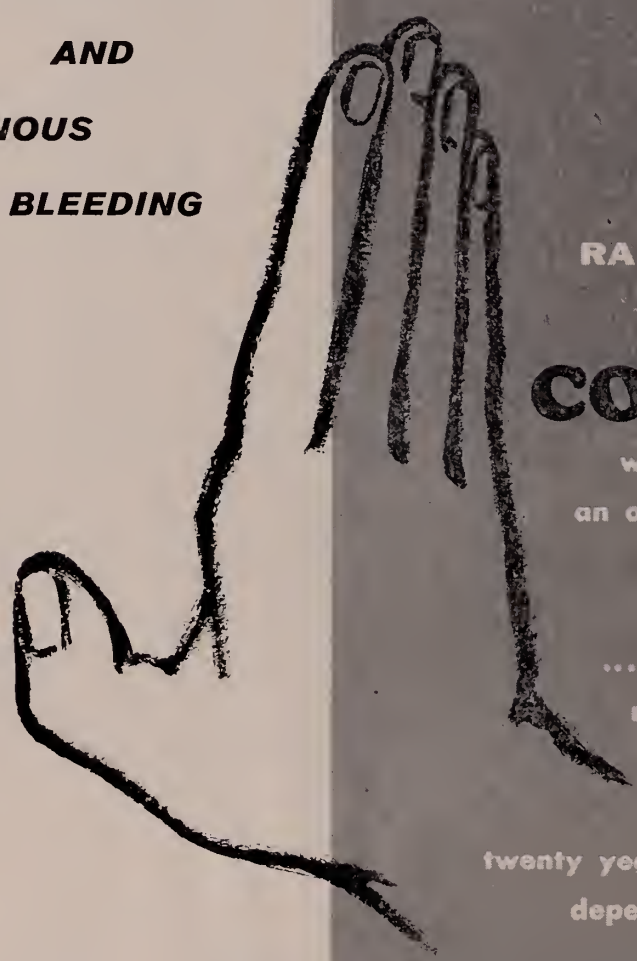
BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

KOAGAMIN®

parenteral hemostat

an aqueous solution of oxalic and malonic acids

FOR CAPILLARY AND VENOUS BLEEDING



RAPID EFFECTIVE CONTROL

with an outstanding **SAFETY** record ...not a single reported adverse effect in over twenty years of continuous dependable service

SUPPLIED IN 10cc MULTIPLE-DOSE VIALS
COMPLETE INFORMATION AVAILABLE ON REQUEST

Chatham CHATHAM PHARMACEUTICALS, INC. • NEWARK 2, NEW JERSEY
DISTRIBUTED IN CANADA BY AUSTIN LABORATORIES • PARIS, CANADA



A special formulation for those troublesome cases of acute nonspecific diarrhea

DONNAGEL®-PG

Donnagel® with paregoric equivalent

Provides greater assurance of more comprehensive relief in acute self-limiting diarrhea through the time-tested effectiveness of two outstanding antidiarrheals—DONNAGEL and a paregoric equivalent. *Tastes good, too!*

Each 30 cc (1 fl oz) contains:

Kaolin

Pectin

Natural belladonna alkaloids hyoscyamine sulfate atropine sulfate hyoscine hydrobromide

Phenobarbital

Suspended in a pleasant flavored

Also available:

DONNAGEL® with NEOMYCIN—for control of bacterial diarrheas.

DONNAGEL®—the basic formula—when paregoric or an antibiotic is not required.

A. H. ROBINS CO., INC. Robins

PROFESSIONAL LIABILITY INSURANCE PROGRAM

officially endorsed by

THE MEDICAL SOCIETY OF NEW JERSEY

PROTECTION for Professional Acts and Professional Premises Liability for members of The Medical Society of New Jersey by the First American Liability Insurance Company.

LOSS CONTROL. Your County Medical Review and Advisory Committee will evaluate malpractice cases and recommend the action which would be most favorable for the Medical Profession, the Defendant Doctor, the Patient and the Public. This program permits understanding of the complex problems involved in such cases and calls for close cooperation between the Medical Profession and Insurance Company.

MEDICO-LEGAL FORMS are furnished to each insured doctor to help in reducing claims or dissatisfied patients. Failure to use forms does not affect the doctor's insurance coverage or his eligibility for insurance.

INSURANCE COUNSELING. Insurance counseling and advice, available at all times, without cost, to help you with your Professional Liability insurance problems.

CANCELLATION. No policy will be cancelled or non-renewed without prior consultation between your Society and the Company and this is a matter of complete cooperation for the best interests of all concerned.

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY

Policies Guaranteed Non-assessable

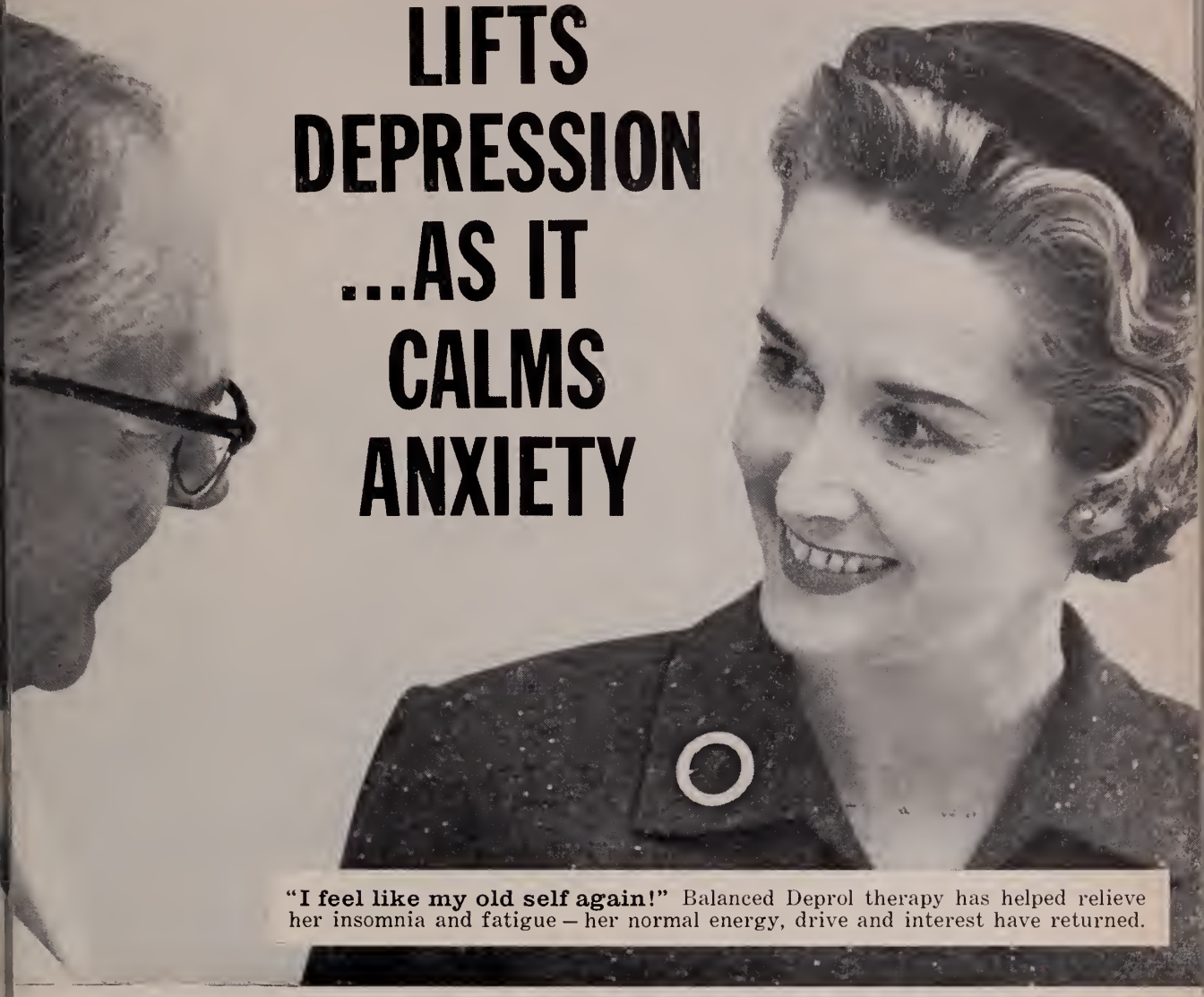
Professional Liability Department

123 CLEVELAND STREET — ORANGE, NEW JERSEY

Joseph A. Britton, Manager — ORange 3-2575

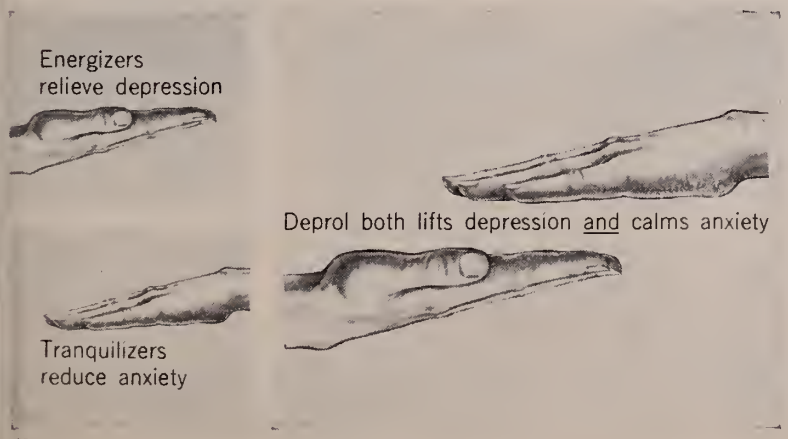
Home Office: Wakefield, Mass.

LIFTS DEPRESSION ...AS IT CALMS ANXIETY



"I feel like my old self again!" Balanced Deprol therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

Brightens mood...relaxes tension



Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be increased gradually up to 3 tablets q.i.d. With establishment of relief, the dose may be reduced gradually to maintenance levels.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets.

Write for literature and samples.

▲Deprol▲®

WALLACE LABORATORIES
Cranbury, N. J.

CD-7393

THIS IS THE COLOR OF PROTECTION



BETADINE—The only germicide whose color indicates a germ-free environment—provides lasting protection and is the most potent non-irritating topical antiseptic known.

for the first time...
a universal microbicidal agent that does not sensitize or retard healing

Betadine®

Povidone-Iodine NND

Kills bacteria, viruses, fungi, yeasts and protozoa on contact. Non-injurious to skin, exposed tissue or mucous membranes.

Products available: Betadine Solution • Betadine Aerosol Spray • Betadine Vaginal Douche • Betadine Vaginal Gel • Betadine Shampoo • Betadine Ointment • Betadine Swab Aids • Betadine Surgical Scrub •

PHYSICIANS PRODUCTS CO., INC.
PETERSBURG, VIRGINIA

for over 12 years dependably effective



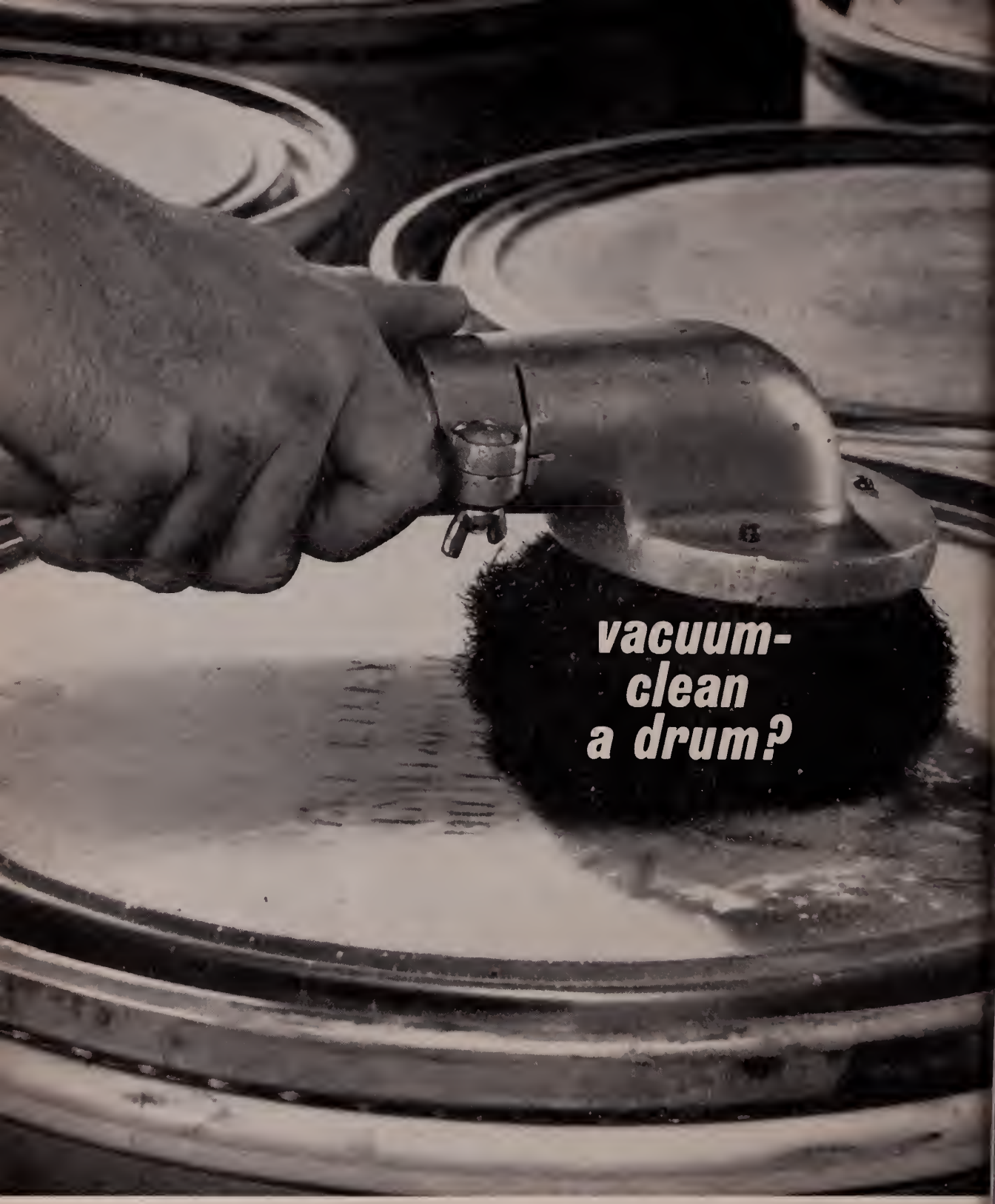
a family of products for family cold needs

CORICIDIN®

for colds

Schering

CORICIDIN,® brand of antihistamine-analgesic-antipyretic compound.



Cleanliness is more than a virtue at Lilly; it is a routine. It starts with vacuum-cleaning the drums filled with raw material even before they enter a Lilly warehouse. It is the first of an endless list of rules that have become a way of life for Lilly employees. Although meticulous housekeeping has little to do with technical know-how, it adds immeasurably to the quality of the finished product.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

390016

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Fussing and Feuding

We open this issue with a talk given by Dr. Wegryn at Bretton Woods (see page 5). Our President there made the valid point that there is too much talk about the image of medicine, and not enough effort to give substance to the image.

In addition to the solid suggestions given by Dr. Wegryn, there is another phase to this problem: what Blaise Alfano* calls the "intra-professional image." The problem here is that, by controversy within its own ranks, our profession has failed to provide an "image" (dreadful word, isn't it?) of a unified corps of men and women working together for the common good. If, for example, general practitioners hurl charges of monopoly at surgeons, and the latter challenge the surgical ability of family doctors, then the layman is bound to believe at least one of the critics; and he can hardly be blamed for a "plague on both your houses" reaction.

More and more physicians are now working on salary. At times, their concerns seem to be at variance with the interests of private practitioners. This is seen in disagreements on such topics as social security for doctors, contract practice, free choice of physician, lines of responsibility, fee schedules, and so on. Occasionally the private practitioner hurls such epithets as "bureaucrat" at the salaried physician; while the latter retorts by offering to exchange income tax returns with the doctor in private practice.

Doctors in research and teaching sometimes look down their noses at "mere practitioners" —who, in turn, brand the former as "mere theorists." Possessors of board diplomas have been known to take digs at colleagues not so equipped. Some try to tell the world that this diploma is the only cachet of expertness. The senior specialist without a board certificate does not take this supinely. He suggests that his very youthful diplomated junior is still a bit wet behind the ears, and adds that you can't beat experience.

*Alfano, Blaise: Journal of Abdominal Surgery, 4:5 (September 1962).

PUBLISHED MONTHLY SINCE 1904
Under the Direction of the Committee on Publication
FRANK L. ROSEN, M.D., *Chairman*

HENRY A. DAVIDSON, M.D., *Editor*
THERESA E. GOEKE, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the Society is entitled to receive a copy of THE JOURNAL every month

Whole Number of Issues 701

VOL. 60, NO. 1 JANUARY, 1963

Single Copies, 30 Cents
Subscriptions, $3.00 per year

All this precipitates an aura of insecurity within the profession. Each of us has something to feel defensive about. As Alfano well puts it:* "The physician cannot play a constructive public relations role until there ceases to be intraprofessional threats to this practice." The suggestion has been made that we develop within organized medicine an arbitration tribunal to settle these feuds behind closed doors. This might lead to charges of censorship or monopoly, but that would seem to be the lesser evil. Internecine feuds damage our self-respect, our sense of security, and our ability to work harmoniously. Medicine has accomplished so many wonders that it would seem to be within our skill and power to resolve this problem too.

I'll Get Me Such a Colored Periwig

The current wig craze can be very educational. First, consider the lesson in etymology. "Wig" is short for "periwig" which comes from "peruke." This comes from *perucca* which means parrot. A person with a wig looks like a parrot. Well, almost. The older periwigs had two knots, and from "topknot" came "toupee." That ends the etymology lesson. Now for the history lesson. Wigs are old stuff. Even Egyptian mummies sometimes had them. They were used by the ancient Greeks and Romans. Greek drama stylized the wig. Black hair plus b'ack beard meant tyrant. Red hair meant villain. Curls at the temples meant hero.

The cosmetic use of wigs goes back to the Romans. Most of the Roman ladies were brunnettes. But in those days, gentlemen preferred blonds. Roman legions had invaded Germany and, in the fashion of soldiers everywhere, found blond frauleins. Some of these consented (with what degree of voluntary cooperation, or for what price, history sayeth not) to have their curls cropped, and enterprising legionnaires made wigs of these blond hairs. The wigs were promptly snapped up in Rome's blonde market. As Roman merchants and soldiers cut channels into the face of Europe they discovered hair of all shades and degrees of curliness. Then a new fashion developed in Rome: change your wig to match your mood or your toga. Mrs. Marcus Aurelius (her name was Faustina) was said to have one hundred wigs, no two alike. (She was a very moody woman.)

By the 17th century, the wig had become part of the costume of a well bred Frenchman or Englishman. (Louis XIII was bald, so his wig did double duty.) Pepys had his own hair trimmed off and invested three pounds in a wig. By the time of the American Revolution, physicians, clergymen, and high ranking Army officers were the only ones who consistently remained bewigged. At the coronation of Queen Victoria, the Archbishop of Canterbury was the only prelate in the Abbey to wear a wig. In Britain today, barristers, judges, the Lord Chancellor, and the Speaker of the House of Commons wear wigs as badges of office.

So ends the history lesson. How about the psychology of wigs? An analyst would have a field day with symbolic explanations. He might point out that "head" has two meanings: the conventional one meaning the top; and the opposite meaning derived from Navy usage. Following standard psycho-analytic practice, he would prefer the lower meaning. Thus wearing a wig would be interpreted as a desire to cover up, or deny the existence of, excretory functions. Most psychiatrists, however, would prefer a simpler explanation. They would point out that the female of our species has always been interested in blending cosmetics, costumes, and accessories. Some women even change their contact lenses to match their clothes; so why not change the coiffure, too? It's as logical, after all, to change the hair-do as to change the costume jewelry.

There are other psychologic factors. In our culture today long hair is a feminine symbol; short cropped hair now goes with the masculine image. Hair is traditionally woman's crowning glory. The firmness with which this is established is reflected in two Biblical quotations from I Corinthians. "If a man have long hair, it is a shame unto him"; and "If a woman have long hair, it is a glory to her for her hair is given as a covering." In 1946, the French loyalists wanted to disgrace the women who collaborated with the Nazis. They did this by cropping their hair, apparently symbolizing the relationship between feminine goodness and thick hair. The "lock" referred to in Pope's "Rape of the Lock" was a lock of hair; and in that poem appears the line "fair tresses man's imperial race insnare"—suggesting again the importance of hair in feminine tactics. Many poets have been enchanted with their ladies' hair. Swinburne wrote once of "kissing her hair, I sat against her feet"; and in a later poem: "her hair had smells of all the sunburned south."

Hair thus has considerable symbolic meaning. In the struggle to avoid grey or lacklustre hair, women spend millions (or maybe billions) on hair-dyes and touch-ups. It might be cheaper and simpler to buy a half-dozen perukes.

Fashion is a cycle of the unpredictable. No one knows why bustles, sheath dresses, hoola hoops, short skirts, long skirts, come and go. Many times in world history wigs have been popular and the wheel seems to be turning into that position once more. The cycle of moustaches in men can be most easily visualized by looking at pictures of our Presidents—the smooth shaven George Washington, the newly bearded Abraham Lincoln, the heavily bearded U. S. Grant, the handsomely mustachioed William Howard Taft, and the smooth skins of Woodrow Wilson and all his successors in the White House. At several times in world history, moustaches were symbols of virility—after all, your endocrines had to be functioning in high gear to raise a moustache. So it may be that the current craze for toupees is simply one more turn in this mystic wave of female fashion. More likely, however, it is a tribute to the symbolic importance of head hair to feminine status. The characteristic pose of the seductive Lorelei[1] is to picture her combing her hair. And, in *Faust,* Goethe warns: "Beware of her hair, for she excels in the magic of her locks: and when she winds a young man's neck, he'll ne'er be free again."

Hair is important to men, too. Remember what happened when Sampson got his hair cut. And the Bald-headed row has special meaning in the American culture today. A V.I.P. is still called a big-wig.

Shakespeare suggests the usefulness of wigs. In "Two Gentlemen of Verona,"[2] a rejected woman says: "Her hair is auburn, mine is perfect yellow: if that be all the difference in his love, I'll get me such a colored periwig."

So, perhaps it's as simple as that.

1. In German legend, not Anita Loos.
2. Italy, not New Jersey.

The Healing Force of Emotion

The disabled person is always running into slogans telling him to be of good cheer and exhorting him to optimism and confidence. While some of this sounds fatuous, the view is essentially sound. The annals of rehabilitation are full of examples of persons who did not know when they were licked; leg amputees who now climb ladders, and 20th century Beethovens who write music which they can never hear.

This triumph of mind over matter is a grand achievement, but we cannot depend on it unless we explain it. The simplest, but least satisfactory, explanation is to assume that we

have two separate areas of human activity, the spiritual and the mechanical. When we see an apparent victory for blind faith, when prayer seems to have been more effective than penicillin, we can, of course, dismiss the whole matter by saying: "Here is something that functions on a spiritual plane, out of the realm of medicine." Most doctors, indeed, are comfortable only when they work with things: scalpels, syringes or sulfonamides; lesions visible to microscope or x-ray; structural changes that can be seen or felt. If a paralysis clears up through hypnotism, if a depression is lifted by the invisible strands of psychotherapy, if a quiet voice calms an hysterical convulsion, this is taken as proof that the symptom was imaginary. The assumption is that if impalpable forces produced a visible change, then the lesion must have been unreal!

Truth is, however, that emotional forces can produce physical effects. This is not a matter of mysticism, poltergeist or faith. It is, if you choose, a matter of mechanics. Consider the blush: an ordinary blush that comes to the face of a maid when she receives a compliment or an insult. The force is surely an emotion; the result is visible alteration in the color of the face, and a change in skin temperature that can be measured with a thermometer. Blood vessels of the skin, then, do respond to emotions. It must be that blood vessels in the stomach or in the joints also respond to emotional forces. Once this is admitted, it must be conceded that if improvement in the circulation to a specific area has any healing quality, then an emotion which sends blood coursing through that tissue also has some curative value. And not just an imaginary or "functional" value either, since this change in blood flow is measurable and real.

Under the stress of certain emotions, saliva will dry up, hair will stand on end, muscles will become tense. All of these are mechanically measurable changes. Excitement may skyrocket the blood pressure, make the blood column pound against the walls of brittle arteries, perhaps thus produce a fatal apoplexy. Conversely relaxation, freedom from worry, buoyant optimism—these will lower the blood pressure and thus cause an ebb in the tide of a chronic and destructive disease. An acute emotion may lead to an acute rise in blood sugar. When a rise in blood sugar becomes chronic, we call it "diabetes." Fear, as the Bible says, "will cause the bowels to turn to water." Let this become a chronic phenomenon, and it gets the label "mucous colitis." Anxiety will increase the acidity of the gastric juices; when acidity is persistent, an ulcer is eaten out of the stomach wall, and what was originally an "emotional" disorder is now something seen on the x-ray film, responsive to pills and powders.

These are but casual instances, plucked out of a vast array of examples, all showing real links between emotions and structural changes. These are, for the most part, instances of the destructive effects of emotions. This is so because medical science is largely a study of bad health, not good health. Our most obvious and dramatic demonstrations of mind-body linkage are examples of disease processes caused by emotions.

But the picture has an inevitable and cheerful converse. Anxiety, fear, immaturity and pessimism can cause destructive structural changes. But then, it follows as the night the day, that hope, maturity and determination can cause reparative physical changes. The confident and optimistic outlook is thus a genuine physical force for the good. This is neither mysticism nor wishful thinking; it is inexorable logic. If the downsweep of emotions can destroy tissue function, then the constructive emotions can heal.

Original Articles • • •

Louis S. Wegryn, M.D.

Elizabeth

A Plea for Constructive Iconoclasm*

The leader of New Jersey medicine here issues a challenging call for more substance and less shadow in the "image" of our profession.

Mr. Toastmaster; my Fellow Guests; distinguished Fellows of the International College of Surgeons; Ladies and Gentlemen;

It is, of course, an honor to have the privilege of addressing you. I appreciate it from the bottom of my heart. It is, however, an honor that is not divorced from a certain sense of anxiety and trepidation—anxiety that I may not in your opinion measure up to the challenge and the potential of this speech situation; trepidation, lest instead of adding to, I detract from, your satisfaction in this evening.

Nor have such efforts as I have made to elicit from others suggestions that would help me to do well here tonight been of measurable assistance. To the question, "What Should I talk about?" the only answer that I have had seems to be, "About ten or fifteen minutes."

As a consequence, I shall have to assume whatever of blame may result for deciding to devote my "ten or fifteen minutes" to the subject, "A plea for constructive iconoclasm," which might be subtitled, "Let's break the images and build men and women instead."

I don't know how you feel about it, but I have grown rather fed up with the sustained public relations emphasis upon the importance of the image of the doctor. Of late, it has seemed to me that people are in danger of concluding that the shadow is more important than the substance; that the image is more important than the reality; that we can improve the image without improving the basic entity that is being imaged or reflected.

I am convinced that an image can be satisfactory only when it is true to the prototype that it represents. If the image is to be improved, added perfection must be developed in that which is being imaged forth. It is useless to try to improve the image as such, directly—as useless as to try directly to change the outlines of a shadow without adjusting instead either the substance, or the source and angle of the light producing the shadow.

I am convinced that our efforts should be dedicated not to the attempt to make doctors *seem* better than they are, but to *be* better than they have been and are, so that they may deservedly merit the respect and love of all who come in contact with them.

It seems to me of fundamental importance that we resist any blandly encouraging notion that the clothes, as it were, can make the man—that tailor's padding is as good as a well-proportioned frame and well-developed muscles.

In medicine we don't try to make people *look* healthy by the free and artistic use of cosmetic aids. Instead we try to make them be truly healthy, confident in the knowledge that if they are truly healthy they will look

*Delivered by Doctor Wegryn on July 3, 1962, at the banquet climaxing the Annual Meeting of the International College of Surgeons at Bretton Woods, New Hampshire. Dr. Wegryn is President of The Medical Society of New Jersey.

healthy, without aid or overlay of cosmetics.

Don't misunderstand me. I support and applaud the idea of getting people to see the doctor as a noble, dedicated, capable, and compassionate person. But I insist that there is only one sound and dependable way of doing it—the doctor must actually be or become noble, dedicated, capable, and compassionate. Then and only then will people see him as such—and then only when they look at him through eyes that are fair and that do not distort that which they look upon.

As a people, we Americans are increasingly inclined to deceive ourselves. The process is largely one of unconscious deception, but nonetheless it is one that we can indulge only to our own essential detriment and disadvantage.

It all comes, I think, of our looking for an "easy" way. It leads us to numberless inanities. Sometimes it makes us seem pitiably foolish, since the indulgence of our various deceptions, for the most part, leaves only ourselves deceived.

As as case in point, I regret to say—and I offer the observation not in a spirit of harsh disapprobation but rather in a spirit of dismay and regret—I cite the way in which some girls and young women of today employ the many so-called "beauty aids," that at great expense of time and money they use to make themselves more "lovely to look at, delightful to see . . . "

I suppose they have evolved an image; but they would, I think, be well advised to recall that "beauty unadorned is beauty at its best"; and in justice to themselves, and in kindness to the world, be encouraged to be themselves—to develop natural health and beauty of body and soul, and to let them shine through in the lyric loveliness of their uncamouflaged and uncalcimined fresh young faces.

This tendency to the cultivation of artificial and misleading images is too much with us all. As individuals, we pose as prosperous when we are in reality living beyond our means and teetering on the verge of economic disaster. We protest that we are demanding our rights when we are clamoring for indulgences that are unearned and undeserved. We avow our love and devotion to our fellowman when we are vigorously active in trying to do him in for our own selfish advantage. We pledge our love for our country when we are doing our best to undermine it by taking from it instead of giving to it, as in justice and duty, we are bound to do. As a people, we cry, "In God We Trust," yet, like Peter, we deny that we know Him, and turn deaf ears to the request that we suffer little children to come unto Him.

As practitioners of medicine, in dealing with our patients, we are at pains to deal with the realities of their conditions. We learn to brush aside the aspects of things as they *seem* to be and to arrive at an appreciation of things *as they really are*. We are practiced in getting to the truth of the patient's health condition. We should encourage the extension of this tendency of investigation and evaluation to all aspects of daily life, for ourselves and our fellow citizens. Let us face up to realities—not to misleading misrepresentation of realities. Let us know things and ourselves as they and we really are, and get to work to bring about real improvements.

What this country needs—at all levels, and in all walks of life—is more men and women of real worth. We of medicine can, by our example, show what could and should be done. We of medicine can make it transcendently clear that our profession is not great *per se*, but that it is great because of the real and genuine worth and excellence of the men and women who give it its life and character.

If we can show this example to our fellow-citizens, we can make a tremendous contribution to the true health and strength of our country. As constructive iconoclasts, we can destroy the false and misleading images that presently are so popularly accepted, and in their places exalt men and women whose dignity, integrity, and genuine worth nobody can deny.

Woodrow Wilson, in his Swarthmore Address, once said, "I cannot accept that a man is an educated man merely because he shows me his diploma. The only way he can prove

it is by showing that his eyes are lifted to some horizon which others less fortunate have not been privileged to see." Wilson was calling for the reality of educational attainment, and rejecting as a substitute therefor merely the external sign and semblance thereof.

In this spirit, we could revivify and enrich all aspects of American life. Certainly we can exalt the honest worth of our profession and its practitioners, and have that worth recognized by men and women everywhere, who will be moved to know and see things not as they are alleged to be, but *as they truly are.*

Let us return to truth—rejecting the innumerable distortions and misrepresentations that are everywhere. And as truth has in the past made us free, in the future it will keep us free.

This is a readjustment and a rededication which, in our country, we must achieve if we are to survive. No cause is more worthy, no undertaking more necessary. No project more promising of genuine reward.

If we succed, as individuals, we shall be better and happier, our profession will advance in honor and in popular regard, and our country will be enriched.

Let's stop building images. Let's start building better men and women everywhere, as our part in building a better world.

257 Elizabeth Avenue

Balance Sheet on Group Practice

In the May 1962 *Medical World News* appears a summary of the assets and liabilities of group medical practice. The balance appears in these terms:

ADVANTAGES OF GROUP PRACTICE

A regular work week assures leisure time
Temporary leave can be taken with knowledge that patients will get care
Special and technical services and the patient's full medical history are available in one location.
Consultation is easily accessible
Relationship of members stimulates and improves the quality of performance
Acquisition and use of the best equipment for diagnosis, therapy and research is possible
Competent business management handles administrative matters, assists in monetary relationship with patients and thus allows full concentration on professional activities.
Young men can enter practice without a heavy investment and with a stable income.
A sense of professional—as well as economic—security is provided

DISADVANTAGES OF GROUP PRACTICE

Specialists with high earning potential seldom realize as large an income as they would in solo practice
Possibility for disagreement exists over division of income
"Outside" physicians are sometimes reluctant to refer patients to specialist-members of groups
Members share and suffer to some degree from errors committed and expenses incurred by associates
Urge for individualistic expression must be curbed at times in favor of group rules, and a member may find himself committed to a policy decision of which he disapproves
An undesirable degree of overspecialization of practice may occur
Patients' freedom of choice may be limited, and intimacy of the patient-doctor relationship diluted
Complaints about being "too scientific" are generally leveled by patients at group rather than solo practitioners
Some men may become more interested in professional and personal security than in excellence of practice, teaching and research

Arthur Winter, M.D

East Orange

Infusion Chemotherapy for Brain and Neck Cancer

Some drugs given by direct arterial introduction may prolong life and alleviate suffering in patients with cancer of the brain and neck

Direct infusion of cytotoxic drugs [10] into the carotid artery [6] has been used [7] for head and neck cancer.[9] The particular interest in these cases to be presented is the specific lessening of the pain and regression of some of the tumors. The infusion technics [8] have varied from 30 minutes up to 3 days.[12]

Three cases of brain tumor (glioblastoma) and three of neck cancer are reported.

CASE ONE

A 63-year old man was admitted for recurrent headaches of 10 days' duration. He had had a right parietal craniotomy two years earlier for a glioblastoma. This had been partly removed. The patient subsequently received a course of deep x-ray therapy for a total of 4,000 r in air in the initial course. This was followed several months later by a second course totaling 2,250 r. These gave symptomatic relief until three months prior to admission when he noted headaches, progressive weakness of the left side of the body, weight loss, loss of balance, and (over the 10 days before admission) progressive lethargy with intractable headaches. On admission, he was well-nourished, well-developed, and well oriented. His gait was hemiparetic. Neurologic findings confirmed a left-sided weakness accompanied by hyperactive deep tendon reflexes. Except for left homonymous hemianopsia, the eye examination, including fundoscopy, was normal. The operative defect site was well-healed, without bulging. Blood count, electrocardiogram, urinalysis, blood glucose and urea nitrogen were normal. Lumbar puncture revealed an initial pressure of 170 mm. of water with xanthochromic fluid, which contained a total protein of 137.5 mg. per cent, with a one plus Pandy. There were 12 white blood cells and two red blood cells per high power field. Electroencephalogram was consistent with a focal lesion in the right hemisphere, superiorly and vertically. Angiogram of the right carotid vessel showed slight displacement of the anterior portion of the peri-callosal artery to the opposite side.

All findings were consistent with a recurrence of the original, incompletely removed, glioblastoma. Since he had already had two craniotomies and two full courses of radiation, a trial of intra-arterial alkylating agent was decided upon and approved by the patient. After conclusion of arteriography, with the injecting needle still in place, 30 mg. of Thio-tepa* were injected slowly over a 20-minute interval without immediate or delayed reaction. He was discharged three days later slightly improved. After the introduction of Thio-tepa,* he was completely relieved of severe headaches. There has been no significant depression of his bone marrow. However, his course in general has been one of gradual deterioration. He became increasingly more stuporous. He refused further therapy and expressed his desire to die. The only thing that can be said is that following the Thio-tepa* infusion, the patient's intractable headache was relieved until he died ten months later.

CASE TWO

An 84-year old housewife was admitted with an inoperable mass involving the right ear and mastoid area. This had been partly resected a year earlier, when the pathologic diagnosis was an infiltrating, moderately differentiated epidermoid carcinoma. She was treated with x-ray therapy without response, and became lethargic, bedridden, and then semi-comatose. By the time of her readmission, she had a right facial paralysis, a destructive right labyrinthitis and a distension of the veins drained by the right lateral venous sinus and the internal jugular vein. X-rays showed extensive destruction of the right temporal, occipital and mastoid bones. Electrocardiogram showed evidence of a left ventricular strain.

*Thio-tepa is the Lederle brand name for triethylene thiophosphoramide.

In view of the rapid invasion of the tumor into the skull and its unresponsiveness to x-ray therapy, it was felt advisable to attempt prolonged intra-arterial infusion according to the technic of Sullivan.[9] Accordingly, a polyethylene catheter was placed into the right external carotid artery, and Bowman pump infusion of Methopterin® 50 mg. daily in 3,000 cc. of five per cent dextrose in water, plus 6 Grams of Citrovorum® factor given intravenously daily as a systemic antidote was begun in combined therapy. This was performed for four consecutive days with a slight increase in reactivity of the patient, but with the appearance of spiking fevers to 104 degrees. Her downhill course continued essentially unabated and she died four days after this therapy. Autopsy showed that the carcinoma had extended through the temporal bone into the cranium and was the primary cause of death. Her fever was contributed to aspiration bronchitis and bronchopneumonia. This patient was too far advanced for any operative procedure. Therefore, proper evaluation as to the effect of the chemotherapy in this case would be difficult. Clinically, the patient showed no change with the Methopterin®.

CASE THREE

A 59-year old man was admitted for carcinoma of the palate with lymph node metastases. This tumor was treated by local palatal resection plus a bilateral radical neck dissection, followed by x-ray therapy to the involved sites. He had a well-differentiated epidermoid carcinoma. He was readmitted a few months later for resection of several recurrent lymph nodes which, on analysis, showed metastatic carcinoma deposits. He returned later for trial with 5-fluoro-uracil. This was given intravenously with a transient remission, though with some adverse systemic reactions. He soon noted, however, weakness, throat pain, dysphagia, anorexia and weight loss. Because of this, he was readmitted and we found recurrence of the palatal growth plus enlarged regional nodes in both cervical chains. The white count was elevated to 14,300 with a slight shift to the left.

His stay was devoted initially to replenishing his nourishment with tube feedings and giving him supervised bedrest. However, five days after admission, he developed a severe aspiration pneumonia with a sputum culture of K. pneumoniae. This responded well to antibiotics, and after his recovery, we decided to try prolonged bilateral intra-arterial infusion of the internal carotid arteries, using 5-fluoro-uracil, the chemotherapeutic agent he had responded to transiently before. Accordingly, polyethylene catheters were inserted into both carotid arteries and daily perfusion of 100 to 1,000 cc. of saline containing 30 mg. of this drug per liter was begun, using the Bowman pump. This was continued daily without incident for eight days when he developed a complete right-sided hemiplegia. The left intra-arterial catheter was removed but infusion was continued through the right one for one more day. In this manner, he received an estimated total of 300 mg. of drug without effect noted on the blood count including the platelets or the blood chemistries, including the urea, Van den Bergh, bilirubin, alkaline phosphatase, serum proteins or transaminase. However, the cephalin flocculation did show a mild elevation to 3 plus. The patient was afebrile during this, except for the day of, and day after, the hemiplegia. This hemiplegia responded to therapy and improved markedly by the day of discharge. The tumor deposits did not show any remarkable response to this therapy. His pains diminished markedly, but the tumor objectively appeared to become slightly larger and edematous. He was discharged two weeks later transiently improved as noted; but within two weeks his pains recurred, and he was admitted to a nursing home. The effect of this infusion must be regarded as completely negative. No maintained improvement could be demonstrated in the tumor or its metastases. A serious complication of therapy, the hemiplegia, resulted from this treatment. One other way of treating such a case in the future might be to infuse with a mixture of chemotherapeutic agents over a 24 to 48-hour period, rather than this prolonged 10-day trial. The longer that chemically reactive catheters (such as polyethylene) remain within a vessel, the greater the chance for such a complication. The patient had only a transient relief of severe pain with 5-fluoro-uracil which lasted for about four weeks.

CASE FOUR

A right-handed, 41-year old man complained that he noted "geometric figures drifting to the left." This was followed by severe and throbbing temporal pain. He thought he had had a brief fever and he knew he had vomited once. He complained also of "light-headedness." Electroencephalogram was normal. Positron scanning suggested an abnormality in the right parietal-occipital region. Neurologic examination revealed only an equivocal left central facial weakness, left hemicorps hypalgesia, and ophthalmoplegia internuclearis. A bruit was heard over the right carotid artery. With the elevated protein of the spinal fluid up to 150 mgm. per cent, the positron report, and the patient's subjective history, craniotomy was done on the right parietal occipital region. Pathologic diagnosis was astrocytoma grade III. He was given a right carotid infusion with 30 mgm. of Thio-tepa* under local anesthesia. This was followed by cobalt therapy, 2,250 r. During the period following the Thio-tepa,* the patient had some nausea which subsided. Before the cobalt therapy was begun, he started to have periods almost completely free of headache. He went to Denmark a month later. The last report (three months later) indicates that his radiation has been completed and that his headache is almost completely gone.

CASE FIVE

A 48-year old left-handed woman had frontal headaches associated with vomiting for four weeks

She had become apathetic. She was well oriented as to time, place and person. There was a left dysmetria and decreased succession on the left. She had hypalgesia of the left arm, left leg and left side of the face. Deep tendon reflexes were equal with a left Hoffman. There was a mild left hemiparesis, and left homonymous hemianopsia, and extinction phenomena on the left and an equivocal left central facial paresis. The clinical impression was a space-occupying lesion in the right fronto-temporal region.

A right carotid angiogram revealed a stain in the right frontal region. Next day, a right fronto-temporal craniotomy was done. A tumor was evident at the surface of the cortex, the border of which was poorly demarcated. Cortical exploration indicated that the tumor extended too far to be completely removed. All we could do was a biopsy and internal decompression. A week later, infusion of the right common carotid was 30 mg. of Thio-tepa* was initiated. Within one week, her headaches were almost completely gone! She was transferred to the Hartford Hospital three days later, and there had radiation therapy, 5,000 r. Headaches completely vanished and the patient has been discharged. Our last communication from Dr. Benjamin Whitcomb, two months later, indicates that she is now home and appears definitely brighter.

CASE SIX

A 72-year old man had difficulty in swallowing. He had pain along the right side of his neck for seven days prior to admission. He had lost 50 pounds over the past two months. Biopsy of the epiglottis showed squamous cell carcinoma. For eight weeks he was given cobalt therapy with transient improvement. Then he had recurrence of symptoms with marked dysphasia and swelling of the submandibular area. There was no response to a trial cobalt therapy at this time. Oral examination revealed necrotic tumor over the epiglottis and back of the throat. He refused a radical neck dissection. Six months later, he did accept a right carotid infusion with 30 mgm. Thio-tepa,* followed by Methotrexate®, and Citrovorum® factor. The catheter was removed with no complications. Within six days, he required no more narcotics for pain. He was able to swallow solid foods, and the neoplasm started to recede. The last report from his attending doctor was three months later. The patient continues to gain weight, has no pain in swallowing, the tumor within the throat is healed and the swelling in the right angle of the jaw is now only one-third of its original size.

The technic of infusion was used here ranging from 20 minutes to three days. The chemotherapeutic agents used, included Thio-tepa,* 5-fluoro-uracil, and Methotrexate.[1 to 5,11] The cases and series are small but include three glioblastomas, two cases of epidermoid carcinoma, and one squamous cell carcinoma. Of the glioblastomas, two are still alive since procedure. One died 30 months after the diagnosis was made and 10 months since infusion. Ordinarily the prognosis for glioblastoma is four to 11 months.

CONCLUSION

THE use of direct infusions of chemotherapeutic drugs has resulted in partial to complete relief of intractable headache in three brain tumor cases, one of them until death. One of the epidermoid carcinomas had only partial relief with recurrence of pain; the other one was in semicomatose condition and pain could not be evaluated. The last patient is still showing regression of his symptoms. There is some modification and regression as a result of the Methotrexate® and Thio-tepa* combination in the last case. The use of certain chemotherapeutic drugs by direct arterial introduction may actually cause prolongation of life and a more comfortable period for a patient with diagnosis of cancer of the brain and neck.

377 South Harrison Street

BIBLIOGRAPHY

1. Klopp, C., *et al.*: Cancer Research, 10:229 (1950).
2. Creech, O.: Journal of the American Medical Association, 169:339 (1959).
3. Creech, O.: Annals of Surgery, 148:616 (1958).
4. Creech, O.: Annals of Surgery, 149:627 (1959).
5. Personal communication from Dr. Creech.
6. Woodhall, B., *et al.*: Annals of Surgery, 150:640 (1959).
7. Personal communication from Dr. B. Woodhall.
8. Wtehlin, J. and Clark, R.: Archives of Surgery, 83:196 (1961).
9. Sullivan, R. D., Miller, E. and Sykes, M.: *Cancer*, 12:1248 (1959).
10. Goodman, L. S. and Gilman, A.: *The Pharmacologic Basis of Therapeutics*. Ed. 2. Macmillan, 1958. New York.
11. Moore, G. E.: Transactions of the St. Petersburg Seminar of the American Cancer Society, March 19, 1961.
12. Winter, Arthur, and Shapiro, M. J.: Journal of the Newark (N.J.) Beth Israel Hospital, 12:4 (1961).

Roy T. Forsberg, M.D

Elizabeth

Anti-Metabolite-Metabolite Intra-arterial Chemotherapy

Attempts to "starve" a cancer by direct intra-arterial infusion are worth making, although this is still essentially a research project.

In recent years, research in cancer chemotherapy has been intensified. Particularly since 1957, new technics have opened a way which may lead to a sound chemo-biologic approach to malignant disease.

Since 1957, Creech and associates of Tulane [1] have been employing perfusion technics with several chemotherapeutic agents with some success in terms of palliation. Of special interest to us has been the work of Sullivan [2] at the Lahey Clinic.

The anti-metabolite-metabolite intra-arterial infusion therapy program as originated by Sullivan [2] has the same rationale as that of other anti-folic preparations: the destruction of neoplastic tissue by blocking the action of folic acid on the cells. If effective, this results in the starvation of the cancer tissue. With amethopterin (Methotrexate®), there is the advantage of neutralizing its action as an anti-metabolite with the metabolite, Citrovourum Factor (Leucovoran). Therefore, high doses of the anti-metabolite can be delivered to a local area while protecting against systemic toxicity. The technic will be illustrated by describing the approach for a lesion on the left side of the tongue.

An upper left cervical incision is made anterior to and parallel with the sternocleidomastoid muscle. By sharp and blunt dissection, the left common carotid artery with its bifurcation is exposed. The external carotid artery is identified. A 5-0 silk purse-string suture is placed on the anterior wall of the upper portion of the common carotid artery. Blalock or bulldog clamps are applied above and below the purse-string suture and an opening is made in the vessel through the center of the purse-string. A plastic catheter, PE-60 is inserted and directed into the external carotid artery. About 2 cc. of a 5 per cent Fluorescin solution is introduced into the catheter and the room darkened. By illuminating the head and neck area with a Wood's lamp, accurate placement of the catheter is easily ascertained by the yellow color of the area of arterial supply. This obviates the need for aortograms, and allows for readjustment if needed. The wound is closed, and the infusion begun with the use of a Bowman pump. This pump which is used to overcome the arterial pressure, can be used for either unilateral or bilateral simultaneous infusions.

Herewith is a report of our experience with this technic: Between April, 1960 and December, 1961, we treated fourteen patients for from three to ten days. Dose was 50 milligrams of Methotrexate® given in a continual arterial infusion in 2000 cc. of 5 per cent glucose in water, plus 6 milligrams of Leucovoran every 6 hours intramuscularly.

Twelve of the fourteen patients had epidermoid carcinoma involving the head and neck region. One was a metastatic adenocarcinoma

1. Creech, O., Jr.: Annals of Surgery, October, 1958.

2. Sullivan, R. D., Miller, E., Sykes, M. P.: *Cancer,* 12:1248 and 12:1262 (Nov.; Dec. 1959).

to the bladder of renal origin. One was a basal cell carcinoma of the left ear. Ten had had extensive surgical and/or radiation therapy. In only three was this the primary therapeutic approach. All patients were in the advanced state of his disease. All diagnoses were confirmed by histopathologic examination.

Sites of primary disease in treated patients were:

Tongue	3	Pharynx	1
Larynx	1	Buccal mucosa	1
Gingiva	1	Submaxillary	1
Parotid	2	Kidney	1
Tonsil	2	Ear	1

We had some *complications*. In three cases the catheter was dislodged and re-inserted. One patient died of coronary occlusion. And three died following cerebro-vascular accidents. Five suffered a leucopenia of under 3000 white cells per cubic millimeters.

Results were classed as follows: three patients had complete regression and five had partial regression. In two there was no discernible regression, and as indicated above, four died.

Regression of the primary tumor is indicated by actual measured decrease in the size of the mass. In half of these, the regression was of short duration, usually about two months.

Response was objectively seen as early as the 5th day of treatment with maximum effect noted by the end of the 21st day. Serial photographs were taken. The leucopenia in all five patients cleared up promptly following cessation of therapy. One patient treated for ten days presented no leucopenia.

One patient is now 10 months post-treatment with no evidence of primary disease. However, he has persistent lymph node metastases. There has been no regression in any lymph node metastases in this series.

Because regression of the primary disease was of relatively short duration, we have tried to improve results by the addition of Cobalt 60 therapy where possible. The ten-month case is one of those so treated.

Nine of the fourteen patients treated since April, 1960 have died of their disease.

Of special interest is the fact that this program is in a general hospital, non-university affiliated. At the Elizabeth (N.J.) General Hospital, funds for this project were granted the investigator by the Medical Staff. In addition, approval was obtained from the Medical Board and the Board of Trustees of the hospital. This was granted following interviews with the hospital attorney, our own attorney, and following notification of our malpractice insurance carrier. Each patient who submitted to the program was fully informed of what was to be done. We detailed all possible complications. Each patient signed a witnessed attestation to this effect. No patients to whom this project was proposed refused treatment, and all were fully aware that they had malignant disease.

CONCLUSIONS

1. Intra-arterial Methotrexate® infusion therapy should be considered as being still in the research phase.

2. An attempt should be made to treat other sites and various histologic types.

3. Response to date has been usually of short duration. This may be enhanced by subsequent courses of infusion therapy or by the addition of Cobalt 60 therapy.

4. Evaluation of a new method in patients having had maximum therapies previously, is difficult.

5. Complications are not infrequent.

6. Attention to medico-legal matters is always important; doubly so in a general hospital.

815 Salem Avenue

Donald J. MacPherson, M.D.
Oradell

Hemolytic Anemia in Infectious Mononucleosis

Mononucleosis rarely co-exists with anemia. In all the literature only 23 cases have been reported of hemolytic anemia co-existing with infectious mononucleosis. Dr. MacPherson here reports a 24th case.

Anemia accompanying infectious mononucleosis is an unusual [1] complication.[2] Houk and McFarland [3] in an exhaustive review of the literature were able to find only 23 cases of infectious mononucleosis complicated by hemolytic anemia. They report that an auto-immune pathogenesis of the anemia was acceptable in only eight of these cases. They also reported the ninth documented case. Jandl, *et al.*[4] include a case of infectious mononucleosis in their study of infections causing hypersplenism. A recent British editorial [5] emphasizes that the rare complications of infectious mononucleosis, including hemolytic anemia, should be investigated and reported.

A 24-year old man was admitted to the hospital with pain in the left lower chest. Ten days earlier he had had general malaise and cough. This had been followed by chills and fever. Treated by his family physician for four days prior to admission, he had received a total of 3000 milligrams of tetracyclin. In addition he was given aspirin and codeine.

On admission, he was a well developed, well nourished man who appeared acutely ill. Temperature on admission was 102.5. No icterus was evident. There was no pharyngeal inflammation. No enlarged lymph nodes were felt. The spleen was thought to be enlarged but it was difficult to palpate this area due to extreme tenderness.

X-ray on admission showed increased linear densities at the base of the left lung, but no definitive diagnosis was made. There was nothing to suggest pleural effusion. Flat plate of the abdomen showed no evidence of obstruction. The spleen appeared to be considerably enlarged, pushing the splenic flexure downward.

Hemoglobin was nine Grams per cent; hematocrit 24 per cent. The white blood count was 16,100. The peripheral blood smear showed 81 per cent lymphocytes, many of which (including many plasmacytoid forms) were atypical. Platelets appeared quantitatively normal on the smear. The erythrocytes showed polychromatophilia and moderate anisocytosis. Spherocytes made up five to ten per cent of the cells. Three nucleated red cells were seen per 100 white cells on the peripheral smear. Sedimentation rate (Westergren) was 90 millimeters; reticulocyte count 12.2 per cent; positive c-reaction protein; total bilirubin 2.5 milligrams per cent (indirect was 1.5 milligrams per cent). Agglutinin titre studies of typhoid O and H, paratyphoid A and B, proteus OX 19 and Brucella abortus were all negative. Urinalysis was within normal limits. The heterophile agglutination presumptive test was positive up to a dilution of 1:1792. Titer remained at the same level after absorption with guinea pig cells. The direct Coombs test was reported as plus-minus. Indirect Coombs tests were done at 4 degrees centigrade and 37 degrees centrigrade, incubating patient's serum with patient's cells as well as patient's serum with known test cells. Both tests done at 4 degree centigrade showed definite agglutination while those at 37 degree centigrade were negative.

1. Wintrobe, M. M.: *Clinical Hematology,* Philadelphia (1961) Lea and Febiger.

2. Thurm, R. H. and Bassen, F. A.: *Blood,* 10:841 (August) 1955.

3. Houk, V. N. and McFarland, W.: Journal of the American Medical Association, 177:210 (July) 1961.

4. Jandl, J. H., *et al.*: New England Journal of Medicine, 264:1063 (May 25) 1961.

5. Editorial: British Medical Journal 1:1553 (June 20) 1959.

During the first five days of hospitalization, his temperature varied from 99 to 101.5 °F. By the fifth day the spleen was palpable 7 centimeters below the left costal margin. The patient had become slightly icteric and he had developed a pharyngitis.

On the seventh hospital day, he was placed on four milligrams of triamcinolone (a prednisone preparation)† three times a day. During the next fourteen days he had a low grade intermittent fever. By the tenth hospital day, total bilirubin was 1.2 milligrams per cent (of which 0.7 was indirect). By the fourteenth day, the leucocyte count had dropped to 4900. Differential count now showed 57 per cent lymphocytes, and 18 per cent of them were atypical. Reticulocyte count was 11.2 per cent; platelets numbered 260,000 per cubic millimeter. Hemoglobin was 10.8 Grams. Repeat heterophile agglutination tests at this time showed a presumptive titer of 1:3584. After absorption with guinea pig antigen, the titer fell to 1:896. Both direct and indirect Coombs tests were now negative. Osmotic fragility studies were normal. The erythrocyte sedimentation rate had fallen to 45 millimeters per hour. Serum protein studies now revealed a total protein of 7.6 Grams. Electrophoresis showed all moieties to be within normal limits except for a slight decrease in alpha-2 down to four per cent against a normal range between 6.6 and 13.5 per cent.

By the nineteenth day of hospitalization the prednisone (triamcinolone†) was decreased to four milligrams twice a day. The hemoglobin was now 12.3 Grams and the hematocrit 35 per cent. On the twenty-third day, the prednisone (Aristocort®) was reduced to four milligrams a day. The spleen had gradually receded in size and was barely palpable at the time of his discharge on the twenty-fifth hospital day. He was then afebrile and his sedimentation rate was 16 millimeters per hour.

It is now one year following his illness, and he is enjoying excellent health. Current laboratory data include hemoglobin at 17 Grams per cent, and a white blood count of 7200. Differential includes 63 segmented forms, 33 lymphocytes, one monocyte and one eosinophil. No atypical lymphocytes or spherocytes are seen. Presumptive heterophile titer is 1:28.

A sample of the patient's blood was forwarded to the Ortho Research Foundation* where it was found to be Group A, Rh positive, probable genotype R_1R_1 (DCe/DCe). The direct Coombs test was negative. The serum of the patient was negative for atypical antibodies when tested by the indirect Coombs technic against a panel of cells. Using enzyme treated cells weak reactions were observed on about half of the cells; however, the patient's own cells reacted as strongly as any of the test cells. These findings indicated a cold antibody and this was confirmed at lower temperatures to be a nonspecific cold antibody reacting on all cells including the patient's own cells.

Bone marrow smears stained with Wright's stain showed marked erythroid activity. Sections of bone marrow particles stained with hematoxylin and eosin were very hyperplastic due to the increase in number of red cell precursors. There was no evidence of granuloma formation in the bone marrow sections.

This case re-emphasizes the fact that the presence of anemia does not rule out infectious mononucleosis. We do not know the part played by tetracyclin and the other therapy that this patient had received prior to hospitalization in the production of his hemolytic anemia. As in other cases[3] is it difficult to evaluate the effect of the prednisone† on this patient's hemolytic process in this accepted self-limited entity.

†We used the Lederle brand, trade named Aristocort®.

*Studies performed at Ortho Research Foundation, Raritan, N. J., through courtesy of Dr. Philip Levine and Marjory Stroup, M.T. (ASCP).

542 Wendel Place

Musings of a Drug Manufacturer

Despite all the seeming inefficiencies of free competition, I would rather be deluged with more medicinal preparations that I know how to use than be forced to sit idle at the bedside of a patient doing nothing because there are not enough drugs to save lives or, at the very least, to bring comfort to my patients. I would rather be accused of trying too hard to market my useful products than to default on marketing and, thus, to lose sales and thereby increase costs. I would rather be stacked up over an airfield for two hours in a 1961 jet than to have the sky all to myself in something like the Wright Brothers' original flying machine. I prefer to suffer the pangs of perplexity in having countless alternatives in the purchase of a new car than to have no choice at all.—Theodore G. Klumpp, M.D., president, Winthrop Laboratories, in *New York Medicine*.

M. A. Roberts, M.D

Newark

Geriatric Surgery*

The ratio of elderly people in the population is rising faster than the total population itself. This raises the question of surgical risk in operating on older people. Dr. Roberts' experience in this area shows how the risks may be minimized.

In the first decade of the second half of this century, there was an increase in the U. S. population of 26 million or a 17 per cent rise; but there was an increase in the number of persons over 65 years of age of 3.2 million, a 30 per cent jump. Now there are 9 million persons 65 years and over; and by 1980 this figure is expected to be close to 15 million, with an average daily increase of 2,000 persons. A recent St. Louis survey showed that in one year 18 per cent of surgical patients were 65 or over in one hospital, and 25 per cent in another.

The 65-year age dividing line is arbitrary, since the biologic or physiologic age is more important than the chronologic age. However, 65 is a practical point of division, at present due to company and government retirement policies, though soon we may consider 75 or 80 years as a better frontier.

MATERIAL AND METHOD

The present report is based on a seven-month personal general surgical experience in a county institution which serves indigent and welfare patients. During this time, 110 operations were performed on 104 patients. Of these, 61 patients were 65 years and older and 65 operations were performed on them; 2 patients had 2 operations each and one had three. Records were screened for age, sex, pre-operative diagnosis, operation, operative findings, anesthetic agent used, intercurrent disease, electrocardiogram and chest plate findings, hospital stay, complications, and cause of death where applicable.

Age. The oldest patient was a 94-year old female. Average age was 78 for 35 females and 26 males. Age distribution follows:

65 - 69 years	9 patients
70 - 74 years	12 patients
75 - 79 years	12 patients
80 - 84 years	16 patients
85 - 89 years	9 patients
90 - 94 years	3 patients

The 65 *operations* are listed below. Six of them were emergencies.

Leg amputations	10
Herniorrhaphy	9
Vein ligations and stripping	6
Hemorrhoidectomy	5
Cholecystectomy and choledochotomy	5
Lysis of adhesions	4
Cholecystectomy	4
Gastrectomy	3
Mastectomy	3
Revision of colostomy	3
Hiatus herniorrhaphy	3
Colon resection	2
Colostomy	2
Choledocho-duodenostomy	2
Appendectomy	1
Tumor of chest wall	1
Mixed tumor of parotid	1
Gastro-enterostomy	1

*From the surgical service of Essex County Hospital, Belleville, N. J.

Complications. Of the 47 patients who had electrocardiographic studies, 37 were abnormal and 10 were normal. Of the 35 chest x-rays, one was normal and 34 were abnormal; with pulmonary fibrosis and emphysema and cardiac enlargement the most common abnormal finding. One patient had arrested tuberculosis. Of the 61 patients, 13 had diabetes, and 32 had arteriosclerotic cardiovascular disease.

Anesthesia. Most of the 65 operations were done under gas-oxygen-ether anesthesia with thiopental induction; spinal anesthesia was used in six cases and procaine local block in two.

RESULTS

Mortality was defined as any death which occurred while the patient was in the hospital. There were nine hospital deaths for an operative mortality of 14 per cent. Acute coronary occlusion occurred twice, one in a 73-year old amputation on the 94th postoperative day, and one on the sixth postoperative day in a 66-year old man on whom a colostomy had been performed. Two patients died with cerebrovascular accidents, one an 88-year old, eight days after cholecystectomy, and one an 82-year old amputee on the 26th postoperative day. The fifth death was in a 92-year old diabetic operated on for obstructive jaundice due to choledocholithiasis. He died on his 43rd postoperative day following massive gastrointestinal hemorrhage. The sixth was in a 70-year old man on whom a gastrectomy was done for bleeding gastric ulcer. On the 60th postoperative day, he had urinary bladder hemorrhage. Suprapubic cystostomy revealed carcinoma of the bladder. He died two days later. A 70-year old woman with obstructive jaundice due to carcinoma of the pancreas was the seventh fatality. Choledocho-duodenostomy had been done to relieve her jaundice though her kidney function was known to be poor. She died in uremia on the ninth day after surgery. The eighth death was in an 82-year old man who had been in the hospital three months with a leg ulcer when he developed acute small bowel obstruction. He had left bundle branch block and left ventricular hypertrophy. Chest x-ray revealed marked cardiac enlargement. A flat plate of the abdomen showed, in the words of the roentgenologist—"immense small bowel." This patient had an emergency operation (under local anesthesia) after four hours of preparation. A gangrenous small bowel due to adhesions was found. This necessitated bowel resection. The operation was completed under general anesthesia; the patient died 24 hours later. Finally, an 88-year old man had cardiac arrest during surgery. This was his fourth admission for recurring episodes of intestinal obstruction which (at previous operations) had proved to be caused by adhesions. Cardiac arrest occurred 25 minutes after the beginning of the operation as the wound was being closed. Thoracotomy was performed and cardiac massage instituted immediately. Fibrillation ensued and was broken by electric shock. After the cardiac rhythm was re-established, the chest was closed but a portable respirator was necessary to maintain breathing. Thirteen hours later, his heart stopped again and further support was of no avail.

The average age of these nine patients was 80 years.

Morbidity. Postoperative stay averaged 41 days, with the longest 267 days and the shortest four days. Twenty-eight patients had a temperature of 100.5 or over for an average of 2½ days after operation. There were four superficial wound infections. None required drainage and all improved under conservative treatment. One patient suffered a cerebral vascular accident with hemiplegia on the first postoperative day. He survived.

MANAGEMENT

No patient was denied operation because of his age. In two instances, a lesser procedure was performed than might have been done on a younger person. A 77-year old woman had carcinoma of the breast. She also had left ventricular hypertrophy, and cardiac enlargement and extensive pulmonary fibrosis and emphysema. She was rated a poor surgical risk, and

we did a simple mastectomy followed by x-ray therapy. There was also an 82-year old man with chronic duodenal ulcer and duodenal obstruction due to scarring. Electrocardiogram showed myocardial damage. A gastro-enterostomy was done rather than a gastric resection.

EVALUATION

IN EVALUATING these older patients, one must decide if the operation carries more risk than non-operative treatment. Many conditions seen at this age, such as gangrene of the extremity, obstructive jaundice, bleeding gastric ulcer, colon tumors, and intestinal obstruction, leave the surgeon little choice but to operate. Once the decision is made to do the surgery, an evaluation is made of the visceral systems most likely to be physiologically subnormal in this age group. These include cardiovascular, pulmonary, urinary, and cerebral. Unlimited medical consultation and cooperation were available for pre-operative evaluation and amelioration of correctable defects. At the Essex County (Belleville) Hospital, chest x-rays and electrocardiograms are almost routine admission procedures.

In this series, antibiotics were not routinely used postoperatively; 19 of the 61 patients were given either penicillin or an antibiotic combination for a maximum of three days. However, antibiotics were used freely and adequately when indicated. Elderly people tolerate injections poorly. Pre-operative correction of blood, fluid, or electrolyte imbalance, diabetic control, digitalization, and gastro-intestinal intubation, as indicated, are no different than in any other age group.

From this experience, the following can be stated: two of 10 amputations died (20 per cent); two of four lysis of adhesions (one with bowel resection) died (50 per cent); one of four cholecystectomies died (25 per cent); one of five cholecystectomy and choledochotomy died (20 per cent); one of the two colostomies died (50 per cent); one of three gastrectomies died (33 per cent); and one of two choledocho-duodenostomies died (50 per cent)

Of the six "emergency operations," only one died—a mortality of 17 per cent, not significantly different from the 14 per cent fatality rate for the whole series of elderly patients. Various authorities have reported mortality rates of from 26 to 39 per cent for emergency surgery among the aged; and nine to 21 per cent for non-emergent surgery in elderly patients. Their figures follow:

Mortality Per Cent	Overall	Emergencies
Harkins	20	26
Clogett	9	37
Welch	21	39
de Peyster and Gilchrist [2]	11	28
Dorsey [3]	12	33
Hay	17	31

A series as small as ours cannot bring out all the factors governing mortality. Larger and more diversified series, however, have shown that pathology has a large bearing on the rate. de Peyster and Gilchrist [2] have shown that gastric surgery for malignancy had a 5 times greater mortality than operations for benign gastric lesions. On the other hand, in colorectal operations, the mortality is one and one-half times greater for surgery of benign disease compared to that for malignancy.

With proper pre- and postoperative care, the risks of surgery in the aging patient can be greatly reduced. Beside the visceral systems mentioned above, it is essential to evaluate the patient as a whole. Personal, individual factors relating to each patient may have a bearing on the outcome. Some patients are much "younger," or "older," physiologically than their chronologic age indicates. The patient's activity or lack of it before coming to surgery is most important. One who has been vegetating in a nursing home is likely to be a poorer risk than one who has been active. It is also necessary not only to judge what a given patient will tolerate in the way of an operative procedure, but how vigorously his postoperative care can be pushed along toward a return to previous or normal health. Early ambulation was attempted in all these patients within their limits of tolerance; but it is of no avail to lift a weak debilitated patient out of bed and tie him in a chair just to say he

was ambulated early. It is wise to individualize each patient's return to normal eating postoperatively. In some elderly patients, the intestinal tracts are sluggish and will not tolerate a normal diet for a long time after operation. The person who has a home and family to return to, makes a much better recovery. Here again is one of those individual, personal factors that seem to bear on the outcome of each case.

CONCLUSIONS

1. Old age is not in itself a contraindication to operation.

2. Cardiovascular, pulmonary, urinary, and cerebral systems should be evaluated pre-operatively and defects corrected insofar as possible.

3. Certain individual, personal factors peculiar to each patient may be important in the management of each case and should be considered in the evaluation of the individual as a whole.

4. Complete cooperation between the surgeon and internist helps to lower the risk of operation.

5. Emergency operations carry a higher mortality. Elective treatment of conditions such as hernia and cholelithiasis before patients reach this age would seem indicated.

86 Washington Street

BIBLIOGRAPHY

1. Bosch, D. T., Islami, A., Tan, C. T. C. and Beling, C. A.: Arch. Surg., 64:269 (1952).
2. de Peyster, F. A. and Gilchrist, R. K.: Arch. Surg., 83:138 (July) 1961.
3. Dorsey, J. M. and Smucker, E. E.: Arch. Surg., 83:634 (Oct.) 1961.
4. Hanlon, C. R.: Journal of the American Medical Association, 174:1827 (3 Dec.) 1960.
5. Haug, C. A. and Dale, W. A.: Arch. Surg., 64:421, 1952.
6. Herron, P. W., Jesseph, J. E. and Harkins, H. N.: Ann. Surg., 152:686 (Oct.) 1960.
7. Wilder, R. J. and Fishbein, R. H.: Surgery, Gynecology and Obstetrics, 113:205 (Aug.) 1961.

Medical Care Costs Less Now

The real cost of medical care, in terms of hours of work to purchase it, is less today than it was 20 years ago. So reports the American Medical Association's Economic Research Department, based on data from the Bureau of Labor Statistics, released in January 1961.

"The time that a factory employee worked in 1959 to purchase a given 'market basket' of medical care was only 61 per cent of the amount of time required in 1939, a decrease of 39 per cent," the A.M.A. reported.

To pay for physicians' services required only 55 per cent as much working time in 1959 as in 1939. In 1959, a worker could earn the money to pay for a constant quantity of surgeons' services in less than half the time required in 1939, the A.M.A. said.

Only one part of medical care—hospital rates—required more working time to cover the increased cost. The factory worker in 1959 put in 122 per cent of the time worked in 1939, in order to purchase the same quantity of hospital services.

The A.M.A. pointed out, however, that qualitative changes in medical practices have resulted in shortened periods of hospitalization. Twenty years ago the average length of stay for a hemorrhoidectomy was 19 days. Today it is 7 days. The average length of stay for an appendectomy was 13 days; today it is only 6 days.

"Included in this decrease of real cost of medical care is the higher quality of today's service," the A.M.A. said. "Research and progress have produced drugs, technological instruments and improved methods in the management of disease which were non-existent 20 years ago."

S. Leon Israel, M.D.

Philadelphia, Pa.

Problems of Infertility*

In this different approach to the problem, Dr. Israel lists and discusses some important but often overlooked factors in fertility.

Viewing the wide field of infertility openly pock-marked with many unsettled issues, I will cover four topics: persistent problems linked to the timing of ovulation; the evident neglect by urologists of testicular biopsy; certain aspects of the surgical treatment of the infertile female; and some unsettled but lively issues demanding more research by neurophysiologists.

TIMING OF OVULATION

In spite of increasing attention to the process of ovulation by scientists and clinicians, no universally acceptable, accurate method of timing ovluation has been developed. It is possible presently to estimate the span of the midportion of the cycle—the time of the estrogen peak, the supposed stimulus to ovulation—recognition of which by no means guarantees that an ovum will be released. We are likewise capable of perceiving, in any given cycle, that ovulation had taken place. The several clinical methods used to identify these two portions of the cycle (the immediately preovulatory and the clearly postovulatory) are reliable. There is no doubt concerning the selective usefulness of daily vaginal smears, repetitive endometrial sampling, frequent observations of the cervical mucus, hormone assays, enzyme tests, and daily recording of the basal body temperature. The last mentioned, being practical, has become the most universally popular method of ovulation detection.

The Temperature Chart. The infertile woman is advised to take her rectal temperature daily upon awakening and to record the morning readings upon a prepared dated chart, enabling the construction of a graph for each cycle. Although accurate oral temperatures are equally satisfactory and certainly more convenient, they are rarely well taken. The biphasic character of the temperature curve during an ovulatory cycle is well known, there being an elevation of about 6 tenths to 8 tenths of a Fahrenheit degree within 48 hours of ovulation. The rise is sustained until about 24 hours before the next menstrual period. This cyclic phenomenon (reflecting the thermogenic property of progesterone) indicates the formation of a corpus luteum.

Timing of ovulation by this method is possible but only after the event had taken place. It is important that patients be made aware of this limitation. Lamentable alteration of sexuality may occur in couples attempting to schedule their intercourse according to the wife's morning temperature.

*Read by invitation, May 15, 1962 at the Annual Meeting of The Medical Society of New Jersey.

Frequency of Intercourse. The neurotic sexual pattern engendered by tightly regulated, thermogenically governed acts of intercourse is to be avoided. Couples intent upon achieving a wanted pregnancy must be advised specifically concerning this issue.

The spontaneous frequency of intercourse in any marriage is influenced by many factors, including the libido of each partner as well as their education, religious attitude, psychosexual orientation, and physical capacity. Some planned modification of the couple's established coital frequency may be required to improve the chances of conception, considering especially the difference in longevity between ovum and spermatozoon. The aim of any suggested alteration should be to keep active spermatozoa in the wife's genital tract during the preovulatory days. The couple should have intercourse every other day, beginning a day or two before the estimated day of ovulation and continuing several days beyond it. In the most frequent type of cycle this schedule may be initiated on day 8 or 9 and carried through day 16 or 17. It does keep spermatozoa in the wife's uterus and oviducts during the time of ovulation. There seems little question but that spermatozoa (the procreative ability of which persists for several days in the upper female genital tract) should be lying in wait for the ovum which is capable of being fertilibed for no more than 12 hours.

The coital schedule should be so described as to prevent anxiety. The too calculated, too pointed a timing of intercourse may predispose to an unnatural conjugal atmosphere, destroying the interpersonal relationships of the partners.

TESTICULAR BIOPSY

It is difficult for a gynecologist, accustomed to frequent biopsy of the endometrium, to comprehend the nearly universal neglect of the valuable diagnostic procedure of testicular biopsy. This histologic evaluation, recommended first by Hotchkiss[8] and applied widely by Charny,[2] has been shown to determine the function of the germinal epithelium with reasonable accuracy. By providing a picture of the activity within the seminiferous tubules, such a biopsy is invaluable in evaluating the process of spermatogenesis. It serves as a guide for future therapy as well as an indication of prognosis. For example, in the presence of azoospermia, the biopsy finding of normal seminiferous tubules is proof that some mechanical obstruction prevents the normally produced spermatozoa from following the tortuous but channelled course toward their eventual ejaculation. Furthermore, the finding of completely degenerated seminiferous tubule epithelium (particularly in association with peritubular fibrosis) indicates an irreparable situation. It provides an opportunity to tell the husband the truth and to help him face his established sterility. If, on the other hand, the spermatogenic epithelium of a man with oligozoospermia is well preserved, remedial measures may be instituted even though there is no specific treatment available.

Testicular biopsy should be done in all men with sperm counts below 15 million per milliliter. If such diagnostic service is made available to the husband (particularly when it is emphasized in advance that it is diagnostic, not therapeutic) he is generally eager to pursue the recommendation in the hope of a definitive answer. It is regrettable that more biopsies are not performed.

SURGICAL TREATMENT OF THE FEMALE

Discussion of the operative treatment of the infertile female usually includes two aspects: (1) mandatory treatment for such obvious symptomatic pelvic disorders as leiomyomata of the uterus and large ovarian cysts and (2) a deliberate attack upon asymptomatic pelvic disease suspected of being the cause of infertility by methods of uncertain outcome, exemplified by tuboplasty. There is, in addition, a little stressed, often overlooked, third surgical aspect: prophylactic measures to pre-

vent operative procedures from causing infertility, as may be illustrated by discussion of intrauterine adhesions.

Myomectomy. The mere presence of uterine leiomyomata in an infertile woman does not imply a causative relation to her barrenness. Their size, number, and location must be considered. Such tumors are etiologically important if they cause either tubal or cervical obstruction and if they are of submucous variety. The latter predispose to habitual abortion either by impeding normal nidation and placentation or by arousing premature uterine contractions. In contemplating myomectomy upon an infertile woman, the physician must undertake complete study of the sterility problem beforehand. This indispensable survey should include fractional hysterosalpingography to determine as accurately as possible the configuration of the uterine cavity as well as the patency of the fallopian tubes. No myomectomy ought to be done because of sterility without absolute knowledge of the fertility potential of the patient's husband.

Ovarian Cystectomy. The presence of a benign cystadenoma, one that approximates 8 to 10 centimeters or more in diameter, is an indication for ovarian cystectomy, a much neglected operation. Such conservation of the ovary is indicated in women whose ovarian tissue is not only functioning but has some years to continue to function. This limits ovarian cystectomy for practical purposes to women under 40 years of age, whose *unquestionably* benign cyst has not undergone torsion, suppuration, or dense adherence to neighboring structures. Preservation of ovarian tissue has no relation to the size of the neoplasm, its successful execution depending entirely upon identifying a capsule. By proceeding carefully, the surgeon will find the enucleation of such a cyst relatively easy, especially if he remembers that adherent portions of the capsule may be circumcised readily with scissors. "Ovarian cystectomy is easy and safe," writes Bonney,[1] "but it requires of the surgeon that he should forego a procedure which achieves a striking result in a startlingly short time for one which, though it takes longer, has a far greater appeal to the connoisseur. There is a pleasure, a pride, and a satisfaction to these conservative operations which cannot be appreciated save by those who have performed them."

Intrauterine Adhesions. It is essential for one who practices urology, gynecology or obstetrics, holding surgical instruments in his hands frequently, to have continuing knowledge of and to maintain persistent respect for the physiologic functions of the organs of reproduction. When the gynecologist operates within the pelvic basin, he knows that he must avoid undue handling of the tubal fimbria, that he should not leave either ovary in a fixed (nonmobile) position, and that he must not permit the uterus to remain in a posture of fixed retroflexion. He is alert to the threat of cervical stenosis from overzealous cauterization or biopsy of the endocervix. Not much attention, however, has been paid to the injury of overvigorous uterine curettage. Use of the sharp curette during postpartum curettage for unavoidable delayed bleeding is commonplace. Based upon the fallacy that organized endometrium is adherent and difficult to remove, the sharp curette is wielded with vigor and removes strips of endometrium through the basal layer. The resultant denuded myometrial areas cause patchy intrauterine adhesions, eventuating in partial or complete obliteration of the uterine cavity.

Faced with a history of either amenorrhea or marked hypomenorrhea following such curettage, the physician should recall the possibility of traumatic closure of the uterine cavity. This condition requires careful graduated dilatation of the upper cervix and lower uterine cavity, often beginning of necessity with a fine surgical probe. Subsequent instillation of a radiopaque medium affords both a diagnostic hysterogram and gentle spreading of the intracavitary adhesions. Such traumatic amenorrhea and the sterility incident to it are preventable disorders; the prophylaxis hinges upon appreciating that the endometrium is more readily removed in depth during postpartum curettage than at any other time.

THE hypothalamus and the forces it represents dominate the control of ovulation and menstruation. This fact has focused attention upon the role of the midbrain in all matters related to reproduction in the female, including such philosophic ideas as the postcoital transport of spermatozoa and the contribution of orgasm to fertility. Little, however, has been said concerning a possible relation of the midbrain to male infertility. Although it is recognized that such neuro-endocrine factors are ephemeral as well as complex, they do come within the purview of this presentation dealing with problems of infertility.

Male Hypothalmic Factor. Practically no attention has been paid to the psyche of the infertile husband by psychiatrists or by psychiatrically-oriented urologists. This is, perhaps, because so little is known concerning the function of the testes in relation to the central nervous system. It is to be hoped that something of value will be gained by looking upon male infertility in the same fashion that one now regards amenorrhea, admitting that such a common disorder is frequently emotionally induced.

The male is probably more vulnerable to psychogenic impairment of fertility than is generally recognized; all too frequently his possible need for sexual counseling is overlooked. Apart from the universally acknowledged factors of impotence and premature ejaculation, there is some evidence to suggest an emotional etiology in certain instances of faulty spermatogenesis, incomplete emission, and even of total retrograde ejaculation with backflow of semen into the urinary bladder.[4] If these alterations of function are possible, it is not too remote to believe (at least, until study proves it otherwise) that neurophysiology has something here to investigate. Indeed, some recent experimental evidence points in this direction, implicating the posterior median eminence as a critical androgenic feedback area.[3]

Postcoital Transport of Spermatozoa. It is nearly 100 years since Sims[13] made the provocative statement (long overlooked) that he had found migratory spermatozoa in the upper reaches of the cervical canal within several minutes of the completion of sexual intercourse. It has now been established[15] that such is actually the case. It is, however, not proved that spermatozoa enter the uterine cavity solely by their own flagellate power. Many believe[7] that some form of vaginal and/or uterine contractility aids the ascension of spermatozoa. Estrogen may play an important role in this mechanism. On the basis of experiments in rabbits, Noyes[11] speculates that some human infertility may arise from poor uterine transport of spermatozoa as a consequence of either altered responses to estrogen or quantitative imbalance of that hormone. It is difficult to put this hypothesis to clinical investgation; Masters[10] attempted it with suggestive but equivocal results.

Any emotional manifestation may upset hypothalamic-pituitary-ovarian relations, creating disturbances and even arrest of ovulation.[12] But it is difficult to prove that ascent of sperm may be hindered by adverse motility of the vaginal and uterine musculature, or that spasm or altered peristalsis of the oviducts may interfere with migration of both sperm and ovum. One may go further afield and hypothesize concerning psychogenic alteration of the biochemical environment within the female genital tract making it inimical to sperm survival, nutrition of the fertilized ovum, and to implantation of the embryo. These errors may, as Sturgis[16] emphasizes, be the result of an anxiety-induced disturbance in the secretion of properly physiologic fluids by the tubes and uterus.

Fertility and Orgasm. The question of a relation between orgasm of the woman and ultimate conception is still unresolved. Seventy-five years ago, Sims[14] wrote: "It is the vulgar opinion, and the opinion of many savants, that, to ensure conception, sexual intercourse should be performed with a certain degree of completeness, that would give an exhaustive satisfaction to both parties at the same moment . . . How often do we hear husbands complain of coldness on the part of the

wives; and attribute to this the failure to procreate. And sometimes wives are disposed to think, though they never complain, that the fault lies with the hasty ejaculation of the husband. Both are wrong."

Pregnancy does occur repeatedly in women who never experience orgasm. Many lines of evidence [5] indicate nonetheless that orgasm is associated with physiologic phenomena [6] conducive to the ascent of spermatozoa in the female genital tract.[10] Sexual arousal and orgasm may be responsible for an oxytocin-stimulated, epinephrine-inhibited pattern of uterine motility that propels spermatozoa upward. Reenforcement of this uterine action may be provided by the motion of the diaphragm caused by the gasping and the abdominal muscle contractions that accompany orgasm, heightening the intra-abdominal negative pressure. The latter may be responsible for a sucking-in, as it were, of cervical mucus that became sperm-laden during ejaculation from the piston-like action of the penis.[15] It may well be that, although female orgasm is not in itself an invariable requirement for conception, its occurrence represents a positive fertility influence of significance. It seems reasonable to conclude by averring once again that the physiologic functions of the female genital tract, including the capacity of orgasm, "are abetted by tranquility and deterred by fear, pain, and anxiety."[9]

807 Spruce Street

A bibliographic listing of 16 citations appears in the author's reprints.

Fluoridation Does Prevent Caries

A. L. Russell and C. L. White, in the 1959 issue of *U.S. Public Health Reports* (74:289), cite a study they made of native-born children in Maryland who were examined yearly following fluoridation of the community water supply in 1952. The degree of caries inhibition was related to the length of fluoride exposure prior to tooth eruption. Little caries-inhibiting effect was observed in *deciduous* dentation among children who were 2 years old or older at the time of fluoridation. The most striking effect was seen among children whose first fluoride exposure occurred during the period of calcification. Similarly, the younger the child at the time of fluoridation the greater the degree of caries inhibition in permanent first molars.

Gout More Prevalent in Women

The incidence of gout in women has been found to be "considerably higher" than generally believed.

The study was based on 74 cases of gouty arthritis seen at two large Detroit hospitals during the past four years.

Writing in the September 1960 Archives of Internal Medicine, R. E. Turner and her colleagues reported that 19 of the 74 patients were women and 45 of the 74 were Negroes.

"In our experience, gouty arthritis is a relatively common disease which can strike both Negro and white, man and woman," they concluded. They added that: "No significant racial differences in the incidence of gout were noted when the figures were compared to statistics for hospital admissions. The incidence of gout in women was found to be considerably higher than is usually reported."

Earle W. Brauer, M.D.

Jersey City

Radiation Therapy in Skin Disease*

Radiation therapy has an important place in the treatment of skin disease—if you know how to use it. And here's how.

No facet of medicine is now receiving more publicity than that of ionizing radiation. Science editors are eager to report on it from papers presented at medical meetings or appearing in the medical press. The present and anticipated radioactive fall-out figures are more interesting, indeed, more important, than the figures on the Stock exchanges; and if the newspaper reader should falter slightly on terms like *rad* or *gonad* dose, he can find a handy glossary somewhere in the Sunday Supplement.

Has this popular knowledge affected the approach of the therapist to a dermatologic problem? Is the physician's management of the patient really altered by the remark: "You're not going to give me x-ray, doctor, are you?"

According to a recent survey[1] of the practice patterns of dermatologists in all geographic areas of the United States, in only four per cent of all cases is x-ray therapy avoided because of patient apprehension. While this survey gives no information on the reduction in the use of ionizing radiation in the last 15 years, it is generally accepted that the decline has been significant.

The records for the 16 years between 1946 and 1961 of one of the most active skin clinics in the East reveal a 77 per cent decline in patient visits for ionizing radiation while the total clinic patient visits declined but 48 per cent. However, since a comparable reduction of 73 per cent was recorded in patient visits for physiotherapy of the non-ionizing type (e.g. ultraviolet light and cryotherapy), one may conclude that influences other than fear and apprehension on the part of the patient or physician are operative. Indeed, this post-war period has produced the most startling advances in drug therapy. The introduction of the cytotoxic agents, corticosteroids, versatile antibiotics, antimalarials and griseofulvin are but a few of the effective drugs which have steadily reduced the indications for physiotherapeutic measures in general and ionizing radiation in particular.

PROTECTION

Since the dawn of the atomic and nuclear era, the public has become subject to increased hazard from radioactive material used in industry and the fall-out resulting from weapons testing. Naturally, governments are interested in (and will probably try to exert more and more control over) the medical use of ionizing radiation which alone accounts for 85 per cent of the genetically significant radiation to which the average person is exposed.[2]

New Jersey has adopted a strong radiation protection code. The dermatologic radiotherapist with reasonably modern equipment can, with little difficulty, conform to paragraph 17.3 of this code titled: *Therapeutic X-ray Installations Operated at Potentials of 60 KVP and Below.* The structural shielding requirement in this section may be permanent or portable.

*Read May 15, 1962 at the Annual Meeting of The Medical Society of New Jersey.

Leaded vinyl is now available† in a variety of thicknesses, colors, widths, and pre-cut tiles for easy application to walls, table tops and floors to meet specified requirements for limiting scatter.

The radiotherapist is professionally obliged to select patients carefully. In addition to the radiosensitivity of dermatoses, special consideration must be given to location and age of the patient. Technics employing "softer" quality radiation are, in general, to be preferred. The apparatus and its installation must conform to established safety standards and be surveyed by a physicist. Thorough draping of the patient is essential. Exposed fields should be reduced in size as much as possible by shielding in addition to the use of cones to protect surrounding skin and reduce the scatter dose to vital organs, particularly the gonads of the young. Worthy of special mention is the hazard to the thyroid[3] when the head, neck or thorax is exposed in childhood. Unfortunately, in this country we have stressed the term *gonad dose* when it is *genetic dose*[4] (the dose to the gonads adjusted to allow for the child expectancy of an individual) that is important. Publicity about this more realistic concept would prevent much unnecessary patient apprehension toward ionizing radiation.

While some of the responsibilities of the practitioner have changed in the past 15 years, his experience and mature judgment in the selection of patients and treatment technic should remain in unchallenged pre-eminence.

Following is a brief current handbook of principles in the use of ionizing radiation for selected skin problems. This practical guide reflects the author's combined experience in an active teaching clinic and office practice. *No implication is intended that roentgen radiation is necessarily the method of choice for the dermatoses discussed.*

THE BENIGN DERMATOSES

IN THE vast majority of benign dermatoses the pathologic process is found within the first millimeter or two of skin. It seems logical, therefore, to apply a radiation beam of a quality which is more than 90 per cent absorbed within the upper third of the corium (a depth of one to two millimeters). This can be achieved with ultra-soft roentgen radiation, also known here as grenz rays or, in Europe, Buckystrahlen, where they have received wide application for more than 35 years. The modern beryllium-windowed roentgen apparatus delivers a high output over a large and uniform field. Newly-devised ionization chambers[5] permit accurate calibration of dosage. The quality of the radiation usually employed is 0.030 mm. Al HVL. The quality should never exceed 0.035 mm. Al HVL.

DOSAGE SCHEDULE

WITH few exceptions, benign dermatoses in which radiation therapy is indicated receive 200 roentgens per week for five weeks. Improvement is usually observed by the second or third week at which time radiation exposure should be reduced in frequency or discontinued entirely. This will commonly occur before five treatments have been administered. Topical therapy may be used concurrently. For recurrent dermatoses, subsequent courses of grenz ray treatment may be instituted following rest periods of four to five months as long as the dermatoses remain radiosensitive. Total grenz radiation in excess of 4500 roentgens has been administered to many patients over a 14-year period without clinically detectable visible sequelae. Lichen simplex chronicus, patches of psoriasis, vesicular eruptions of the hands and chronic dermatidides are the more common benign dermatoses with a rapid response to this modality.

The exceptions to this routine among benign conditions are acne vulgaris, paronychia due to candida albicans, dermatoses producing extreme hyperkeratosis and synovial cysts which should be treated with superficial roentgen radiation having a beam quality between 0.7 and 1 millimeter Al HVL. The dosage

†From Cordo Chemical Corporation, Norwalk, Conn.; and from Picker X-Ray Corporation, New York City.

schedule is 85 roentgens weekly, with a maximum of 1025 roentgens to any one area. Extensive follow-up studies by Sulzberger, Baer and Borota[6] on over 2900 patients receiving superficial roentgen radiation 5 to 23 years previously revealed the absence of radiation sequelae when treated with such a schedule. One quickly observes that the beam quality of superficial roentgen radiation has materially "softened" in the post-war period. Undoubtedly this trend will continue in succeeding years.

EPITHELIOMAS

Basal cell and prickle cell epitheliomas have been competently treated with ionizing radiation for many years. Innumerable effective schedules have been described. The following routine was devised many years ago in order to conform with a specific office and clinic time-pattern.

The epithelioma is shielded to within 5 millimeters of its clinically visible border and exposed to radiation having a beam quality of 0.7 to 1 millimeter A1 HVL. Basal cell epitheliomas receive 680 roentgens every other day for five treatments to a total of 3400 r; prickle cell epitheliomas receive 680 roentgens every other day for 8 treatments to a total of 5440 r. It is essential to produce an acute radiodermatitis which usually reaches its peak approximately three weeks after the last treatment and heals within an additional three to four week period. The cosmetic results achieved have been excellent and the five-year cure rate is in the order of 95 per cent. Despite consistent and recent adverse reports[7] these tumors respond and heal just as well when situated over cartilaginous sites as other foci on the head and neck. This technic should *not* be applied to epitheliomas situated elsewhere than the head and neck because persistent ulcerations and exceedingly slow healing is more likely, especially on the lower extremities.

‡The Picker Zephyr 60 equipped with an OEG 60 Machlett tube.

EPITHELIOMA IN SITU

Bowen's disease, and multicentric superficial basal cell epithelioma may be treated with grenz radiation (HVL 0.030 millimeters A1). The schedule is 500 roentgens every other day for ten treatments to a total of 5000 r over an area shielded to five millimeters from the clinical border of the tumor. A very mild radio-reaction occurs with slow healing over a four to six week period. Any part of the body may be treated by this technic.

SPECIAL MODALITIES AND RADIOACTIVE ISOTOPES

Teleroentgen radiation: Based on reports[8] in the literature, certain generalized dermatoses, mycosis fungoides in particular, have been treated for palliation with relatively soft radiation (HVL 0.2 millimeters A1 or 2 millimeters water) generated by a standard x-ray apparatus‡ with a beryllium-windowed tube placed at a distance of two meters from the skin.[8] The entire anterior surface of the body is treated with 50 roentgens in one exposure with a similar treatment to the posterior surface of the body every other day for nine treatments. The eyes of the patient and the genitals of men are shielded. Symptomatic improvement is usually observed by the fourth treatment with a complete remission in mycosis fungoides (except the tumor stage) at the end of the course. The remission lasts eight to 16 weeks or longer. Subsequent courses may be given, without danger of visceral or hematopoetic damage until radioresistance of the lesions occurs. This relatively new palliative technic has proved to be of great benefit. It was the subject of discussion at the Twelfth International Congress of Dermatology in Washington in September 1962, together with the achievements of the cathode beam. This latter type of radiation is emitted by an apparatus which is a modified Van de Graaff generator. Its cost and size precludes further useful description in this report.

Radioactive materials: Today, radium ther-

apy by dermatologists is near extinction in this part of the country.[9] Since keloids and cavernous hemangiomas respond well to the gamma rays of radium, one may mourn this loss. Results with radioactive cobalt duplicate those with radium. However, since the skill required to handle radioactive cobalt is as difficult to acquire as with radium and the esposure hazard as great, it is doubtful that dermatologists will embrace this form of radiation therapy.

Thorium X in alcohol has produced significant blanching in 20 per cent of cases of nevus flammeus treated. It is well worth a trial in all instances where underlying tissue hypertrophy is absent. The alcoholic preparation* (300 micro curies per cubic centimeter) is painted on the previously cleansed skin surface and covered with flexible collodion. Treatments should be spaced a minimum of five weeks apart. Fifteen to twenty such treatments may be administered to individuals of any age without hazard.

Strontium 90 (beta) plaques are available. I am thoroughly familiar with its capabilities and I do not believe that it has a place in the treatment of diseases of the skin at this time.[10]

Although radioactive isotopes are being successfully employed as diagnostic aids in other medical disciplines, there is as yet no area in dermatology for this special tool. Intravenous radioactive phosphorus has been used [11] in an attempt to differentiate the malignant melonoma from the benign pigmented nevus. Unfortunately this has proved highly unreliable [12,13] and should be abandoned in its present form.

SUMMARY

Fewer patients with skin problems are receiving ionizing radiation as a premediated therapy. This is due, in large measure, to recent advances in drug therapy rather than fear and apprehension of the modality by the patient or physician. The responsibilities of the radiotherapist have become greater to protect the patient from unnecessary as well as scattered radiation. There should be no difficulty in conforming to the State Code for radiation protection recently adopted without limiting the effectiveness of the ionizing beam. A review of practical successful working schedules for the treatment of skin diseases with ionizing radiation is presented; the technics described easily conform to the requirements of the Radiation Protection Code of the State of New Jersey.

*Thorium X is available from Fleischman, Burd & Co., Inc., 1271 Avenue of the Americas, New York 20, N. Y.

40 Journal Square

BIBLIOGRAPHY

1. Welton, D. G. and Greenberg, B. G.: A.M.A. Arch. Derm., 83:355 (March) 1961.

2. Dullum, D. F.: California Med., 94:295 (May) 1961.

3. Clark, D. E.: JAMA, 159:1007 (November 5) 1955.

4. Radiological Hazards to Patients, Second Report of Committee, Ministry of Health, Department of Health for Scotland; Her Majesty's Stationery Office, London, 1960.

5. Witten, V. H.; Grisewood, E. N. and Oshry, E.: J. Invest. Dermat., 24:365 (1955).

6. Sulzberger, M. B., Baer, R. L. and Borota, A.: A.M.A. Arch. Dermat. and Syph., 65:639 (1952).

7. Frazell, E. L. and Martin, H.: World-Wide Abstracts, 4:34 (1961).

8. Schirren, C. G.: J. Invest. Dermat., 24:463 (April) 1955.

9. Brauer, E. W.: The Medical Clinics of North America, 43:705 (May) 1959.

10. Witten, V. H., Brauer, E. W., Holmstrom, V. and Loevinger, R.: J. Invest. Dermat., 23:271 (October) 1954.

11. Bauer, F. K. and Steffen, C. G.: J.A.M.A., 158:563 (June 18) 1955.

12. Brauer, E. W., Kopf, A. W., Witten, V. H., Berman, M. and Cave, V. G.: J.A.M.A. 172:1753 (April 16) 1958.

13. Schumacher, W., Schwarz, E. and Weise, H. J.: *Strahlentherapie,* 113:443 (1960).

I. M. Schnee, M.D.

Paterson

Recent Technics of Tympanoplasty*

Conductive deafness associated with middle ear infection is often helped by tympanoplasty. Dr. Schnee tells us how to do it.

The word "tympanoplasty" means plastic reconstruction of the tympanic cavity. In practice, however, it implies thorough eradication of disease in the middle ear and mastoid. This must be done prior to reconstructive surgery.

INDICATIONS

Tympanoplasty is indicated in conductive deafness associated with middle ear infection. The hearing loss (which varies in degree in different cases) may be purely conductive; or there may be an additional perceptive factor. In that case, the possible hearing restoration is limited by the extent of bone conduction level. Chronic infection results in pathologic changes in the tympanic membrane, middle ear, ossicular chain, eustachian tube, round window, oval window and mastoid. The ear discharge may be serous, mucous or purulent. There may be granulations, polyps and cholesteatoma. Portions (or most) of the ossicular chain may be destroyed. Retractions, adhesions, and ankylosis of the ossicle joints may occur. Also frequent is tympanosclerosis, which consists of hyelinized collagen deposits.

The aim of the operation is eradication of disease from the middle ear and mastoid and the performance of surgery for reconstruction of a sound-conducting mechanism.

The principles for this surgery were laid down about a decade ago by Wullstein[1] and Zollner[2] in Germany. The extent of "clean-up" surgery varies from just middle ear surgery, leaving the ossicles intact, to total radical mastoidectomy. Post-auricular skin may be used for creating a new ear drum. A middle ear cavity which communicates with a patent eustachian tube and contains a mobile round window membrane and an oval window may be connected by a mobile stapes (or more of the ossicular chain) to the new drum. In some cases, restoration of function is achieved only by the creation of a cavity. Then, fenestration of the horizontal, semi-circular canal was done. In still others, a micro-cavity is created by exposing the mobile footplate to direct sound perception.

Personal experience, and that of others doing this type of surgery for a few years after its inception, brought to light many drawbacks. Using both hearing improvement and control of infection as criteria, the over-all results were successful in about 50 per cent of the cases. Some of the reasons for such a high incidence of failures are: sloughing of the skin graft, perforation, cholesteatoma formation, adhesions, desquamation of skin and persistence of

*Presented before the Section on Otolaryngology, Annual Meeting, The Medical Society of New Jersey, May 16, 1962.

1. Wullstein, H.: Annals of Otology, Rhinology and Laryngology, 65:1020 (December) 1956.

2. Zollner, F.: Journal of Laryngology and Otology, 69:637 (October) 1955.

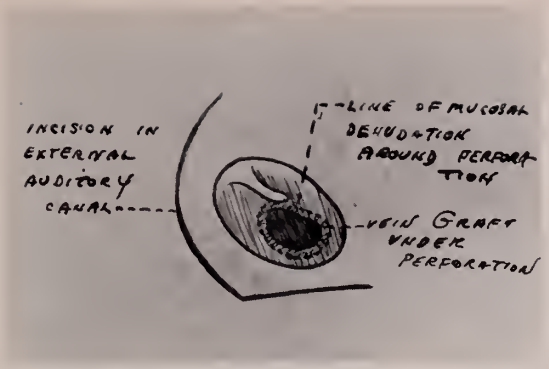


Figure 1. Diagram showing meatal incision, perforation of tympanic membrane and line of mucosal de-epithelialization for vein graft placement.

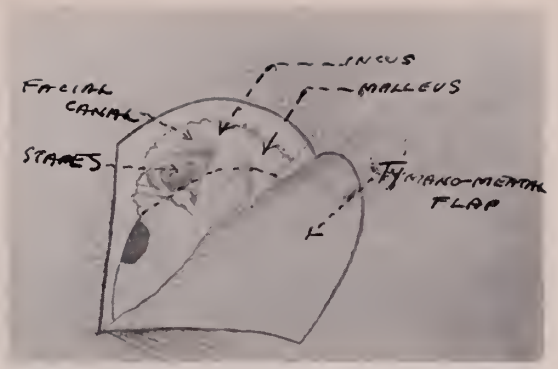


Figure 2. Tympano-meatal flap elevated and annular bone removed to expose middle ear contents.

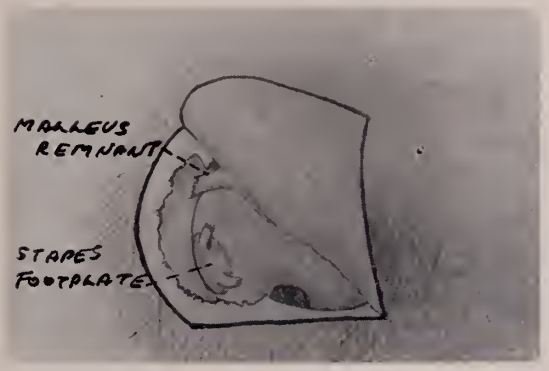


Figure 3. Remnants of ossicular chain to be used in reconstruction with polyethylene and wire.

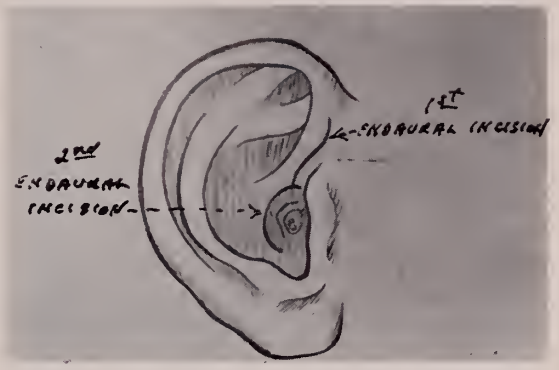


Figure 4. Endaural incisions used to expose mastoid. Also shown are ear drum, perforation and meatal incision.

infection. The skin (because of its consistency and weight) is not an ideal substitute for the ear drum. Creation of a mastoid bowl required life-time care, and is subject to re-infection.

Because of this, otologic surgeons were looking for other sources of material for closure of the tympanic cavity. Use was made of split skin from extremities, skin from the external auditory canal, fascia and muscle flaps.

MOST RECENT DEVELOPMENT

Two years ago, a new approach to this problem was made by several workers, primarily by Austin and Shea.[3] This new technic includes (1) Use of a vein graft for repair of the drum defect, (2) Middle ear surgery done transmeatally by a stapes type of approach, (3) Mastoid by the endaural approach, preserving the posterior canal wall, (4) Polyethylene prosthesis for reconstruction of the ossicular chain.

The procedure I use is based on this recent development, with several modifications. I have used it in all tympanoplasties in the last two years.

When the ear is dry, the middle ear and mastoid surgery and the reconstructive work are done in one stage. In wet ears, the middle ear and mastoid surgery is done as a first stage and the reconstruction in the second stage after the ear has remained dry for a period of time.

Using 2 per cent lidocaine-epinephrine† locally, supplemented with intravenous narcosis, intermittently, a stapes operation type of incision is made in the skin of the external auditory canal, ex-

†The proprietary brand of lidocaine-epinephrine we used was Xylocaine®-Adrenalin®.

3. Austin, D. and Shea, J.: *Laryngoscope,* 71:596 (June) 1961.

tending from about 12 to six o'clock, about eight millimeters from the annulus. Prior to that, the perforation is prepared by removing the margin with a punch forceps and denuding two millimeters of the mucosal surface of the margin. Then the tympano-meatal flap is elevated and middle ear surgery performed, removing granulations, polyps, cholesteatoma, adhesions and tympanosclerosis. The eustachian tube, the oval and round windows, and ossicular chain are thoroughly explored. Atticotomy and antrotomy are partly performed after removing as much annular bone as is necessary. Diseased portions of the ossicular chain are removed.

Following this, two modified endaural incisions are made. The first in circular fashion at the level of the outer end of the external auditory canal, posteriorly, from about two to six o'clock. The second incision begins at the first, at the junction of the superior and posterior wall, extending upward in front of the helix to the level of the inferior crus of the antihelix. Good exposure of the mastoid is obtained with two self-retaining retractors. An extended mastoidectomy is done, preserving the posterior canal wall. The atticotomy is completed through the mastoid cavity. The ossicles are preserved or removed as indicated by disease.

A section of vein is then taken from the anticubital space in the arm, trimmed to size and placed under the perforation, with the adventitia toward the middle ear, supported by Gelfoam®.

The ossicular chain is reconstructed with No. 90 polyethylene tubing and stainless steel wire, connecting the incus or the malleus to a mobile footplate. The drum may be connected to a mobile stapes, producing a columnella effect. In some cases of footplate fixation due to tympanosclerosis or otosclerosis a stapedectomy is done, using fat or vein graft to cover the oval window.

MODIFICATION

IN SOME cases, the posterior bony canal wall is in the way of the desirable approach to the diseased area. In this situation, I use an osteoplastic flap. A superior osteotomy is done with fine burrs at the zygomatic level and an inferior osteotomy is performed at the level of the facial angle. The mobilized segment of bony canal wall remains attached to the skin. This osteoplastic flap may be rotated or advanced forward to provide access to otherwise inaccessible areas in the mastoid and middle ear. At the end of the operation it is replaced in its normal position, preserving the normal anatomy of the posterior bony canal wall.

SUMMARY

TYMPANOPLASTY is indicated in conductive deafness associated with middle ear infection. The aim of the operation is to eradicate pathology and restore hearing. This involves mastoid and middle ear surgery and reconstruction of a conducting mechanism. Postauricular skin has been used for the new drum. A new technic aims additionally at preservation of the normal anatomy. This eliminates a permanent mastoid bowl. The middle ear surgery is done through the external auditory canal. The mastoidectomy, through endaural incisions, preserves the posterior canal wall. The drum defect is repaired with vein graft. The ossicular chain is reconstructed with polyethylene and wire. A modification, creating an osteoplastic flap, is presented by the author. This makes this latest technic of tympanoplasty even more widely applicable.

586 East 25th Street

Should the Adopted Child Be Told?

In a survey of physicians on the subject of adoption by *Patterns of Disease*, a monthly Parke, Davis & Company publication for the medical profession, 49 per cent of the more than 5,000 who responded said children should be told they were adopted before they reach the age of six. Children should be informed between the ages of six and twelve according to 28 per cent, and after thirteen according to 15 per cent. Some six per cent believe children should not be told at all.

George N. J. Sommer, Jr., M.D.

Trenton

Tracheotomy in the Treatment of Thoracic Injuries*

Tracheotomy can be life-saving in chest injuries—but it is not an innocuous procedure and it requires meticulous follow-up care.

The treatment of thoracic injuries may be a simple problem in uncomplicated and mild cases. Only too often, however, serious thoracic injuries are complicated by multiple injuries of other portions of the body. While thoracic damage is often the most important trauma in multiple injury cases, the patient must be totally evaluated and proper care taken of all aspects of each case. Serious head, abdominal, and extremity injuries with hemorrhage may take precedence over the thoracic injuries. The control of serious hemorrhage, whatever the site, is of prime importance. Resuscitation by various indicated measures such as blood transfusion must be promptly started and continued as necessary.

Let us assume that proper total care of the patient is being carried out. The thoracic injuries under discussion are closed, although similar treatment may apply to major open thoracic injuries so well described by Brewer et al.[2] The improvement of respiratory exchange is the object of tracheotomy used in conjunction with other therapeutic measures.

Carter and Giuseffii,[3,4] in proposing tracheotomy in crushing injuries of the chest, divided its benefits into mechanical and physiologic categories. The former comprises the ability to maintain a clear airway by ready removal of fluid and blood from the respiratory track and the relief of laryngeal obstruction from edema, bleeding, and faulty function of the vocal cords. The physiologic effects are the decrease in the volume of dead space in the respiratory tract with a resulting increase in effective ventilation and a decrease in resistance to breathing both on inspiration and expiration. These authors deserve great credit for their advocacy of the use of tracheotomy in crushing injuries of the chest. It is current practice to extend this to seemingly less serious injuries and to use this measure more frequently and with less hesitancy as experience has increased.

MECHANICAL BENEFITS

The use of tracheotomy for laryngeal obstruction from edema and malfunction of the vocal cords (or from bleeding in the upper respiratory tract) is one of long standing. Particular emphasis should be laid upon supraglottic bleeding due to injuries of the face and mouth. Tracheotomy should be promptly carried out in such cases, which may be accompanied by brain injuries, whether or not thor-

*This paper was read May 14, 1962 at the Annual Meeting of The Medical Society of New Jersey. This work is from St Francis Hospital in Trenton.

acic injury is present unless the bleeding can be readily controlled.

The importance of retained bronchial secretions and blood from pulmonary injuries has been recognized for a long time in conjunction with the prevention and treatment of pulmonary atelectasis. The clearing of such materials from the tracheobronchial tree is impaired by the pain of the fractured ribs and the ineffective tussive effort due to paradoxical movement of the flail chest. Furthermore, the older patient with seemingly less severe injuries but with pre-existing chronic bronchitis and emphysema often is unable properly to clear secretions by voluntary coughing. In all these cases endobronchial catheter suction and bronchoscopy have been standard methods of treatment. These methods, however, require for bronchoscopy particular skill and special instruments, and for endobronchial suction the attention of a physician. Repeated bronchoscopy and endobronchial suction may be used in difficult and prolonged cases. But if they do not seem effective (or whenever the surgeon believes that more frequent aspiration is proper) tracheotomy should be carried out. One should not hesitate, when in doubt, to use tracheotomy for the removal of secretions.

CASE ONE

A seventy-six year old man was admitted on March 1 after an automobile accident. He had signs of moderate cerebral contusion, abrasions of the face, and probable rib fractures on the right. He was seen in consultation on March 5 because of a wet, nonproductive cough and clinical and roentgenographic signs of a right pleural effusion.

Endobronchial suction was carried out several times for the next 48 hours with moderate success and with some difficulty in the introduction of the catheter through the nose into the trachea. On March 7, tracheotomy was done with improvement in the patient's breathing and with ready and frequent aspiration of the thin, glairy secretions. Inhalation aerosol therapy was facilitated. The patient remained only partly cooperative for several days and was then able to be out of bed with continued aspiration. The tracheotomy tube was removed on March 26. Repeated thoracenteses removed a moderate amount of bloody fluid from the right hemithorax, but complete removal was prevented by clotting of the blood in the pleural cavity. Four transfusions were necessary to restore a normal blood picture. The patient was discharged on March 31.

In this case earlier aspiration of the bronchi and earlier tracheotomy were advisable. The patient was a big, deep chested man, who had been a heavy smoker. This type of patient has the secretions of chronic bronchitis to complicate the effects of the thoracic injury. Definite rib fractures were not demonstrable due to the basalar hemothorax.

PHYSIOLOGIC EFFECTS

CARTER and Giuseffi[3,4] have described the reduction of dead space in the respiratory tract by tracheotomy in injured patients with reduced tidal air volume due to paradoxical movement of the thoracic wall. They estimate the dead space reduction to be about 100 cubic centimeters, an important amount in these patients whose tidal air volume is about 500 cubic centimeters. Furthermore, the reduction in resistance to inspiration and expiration is of great importance. These effects may be strikingly apparent as observed immediately after tracheotomy has been done in patients with paradoxical movement due to severe rib fractures.

Severe paradoxical movement and respiratory difficulty is particularly present in thoracic injuries, when anterior ribs are fractured extensively. In these patients some form of external fixation has been standard practice combined with tracheotomy. These measures of fixation are difficult to maintain and are often only moderately effective. Open fixation by wiring may be used at times but is a dangerous procedure in critically ill patients.

Avery, Morch, and Benson[1] introduced the piston type intermittent positive pressure respiratory developed by Morch to control and carry on respiration in patients with unstable thoracic walls. With this apparatus ventilation is carried out through an uncuffed tracheotomy tube of special design, which is also available for the aspiration of bronchial secretions. The stroke volume of the piston is adjusted for the requirements of the patient. A

"check valve" in the system near the tracheotomy tube provides for exhalation as soon as the proper amount of inspiratory air has been delivered. The leak of air through the larynx provides a safety valve against excessive pressures in the lungs and prevents secretions from being aspirated through the larynx. Proper humidity is maintained by the passage of air through the humidifier containing five per cent alcohol in water. Should bronchial secretions be viscid or should severe crusting develop, diluted Alevaire® (1 to 4) may be used as a detergent or diluted Tryptar® enzyme digestant may be used as necessary.

Mortality rates from crushing injuries of the thorax are high due to physiologic unbalances created by hypoventilation due to paradoxical movement of the thoracic wall, injury to the pulmonary tissue, pulmonary edema, collapse due to pneumothorax, and to bronchial and tracheal obstruction due to bronchial secretions and blood. Carbon dioxide retention and respiratory acidosis increase respiratory effort with resulting worsening of paradoxical movement and aggravation of the patient's poor physiological condition. The mechanical hyperventilation, following the removal of secretions, eliminates paradoxical movement, improves ventilation, and produces mild respiratory alkalosis with reduction of the respiratory effort.

CASE TWO

A 53-year old woman was admitted at 2:30 a.m. on November 30 following an automobile accident. She had sustained fractures of the second to eighth ribs on the left side and of the right first to fifth ribs; a left hemopneumothorax was present and severe paradoxical movement. In addition, she had fractures of the left olecranon, the right clavicle, the left ischium, and the pubic bones. Tracheotomy was delayed until 7:00 p.m. when the Morch respirator was available. A gastric tube was inserted to relieve gastric dilatation and because of possible visceral injury (actually she had none). The hematocrit on admission was 40 and later in the day 36. Blood and plasma, 2500 cubic centimeters and 500 cubic centimeters respectively, were given on the day of admission and again on the next day (500 cubic centimeters each). The blood picture was then satisfactory and illustrates the extensive blood replacement so often necessary in the resuscitation of the patient with multiple injuries and in particular with injuries of the pelvic bones. Closed intercostal drainage was carried out on December 1 with 750 cubic centimeters of bloody fluid draining promptly and the left lung expanding swiftly and satisfactorily. The drainage tube was removed in three days.

The Morch pump was set to deliver 500 cubic centimeters of air 20 times a minute and was kept adjusted in action until December 16. On December 1, the carbon dioxide combining power was 19.1 milliequivalents. It fell to 15 milliequivalents and 12.8 milliequivalents on December 8 and 14 respectively. It rose to 17 on December 16 and to 22 on December 24.

Constant attention to the tracheotomy tube was required to keep it unobstructed by crusting secretions. Frequent aspiration of the tracheobronchial tree was necessary for the removal of secretions. Intermittent use of the respirator was required for only the few days prior to its removal on December 16. After this tube was removed, attention could be turned to the patient's other injuries with an open reduction of the olecranon carried out. She was discharged on February 18.

The care of this seriously ill patient was greatly facilitated by the use of the internal positive pressure respirator. The paradoxical movement was well controlled. Closed drainage removed the blood and air from the left pleural cavity. The large amount of blood lost in such cases cannot be too much emphasized nor the large amounts required to restore blood volume. Even with mechanical hyperventilation and suction through the tracheotomy tube moderate respiratory acidosis occurred.

CASE THREE

A 46-year old man was admitted at 11:30 p.m. after being run over by a car. He had fractures of the left third to seventh ribs and of the right seventh to twelfth ribs. A left hemopneumothorax was present. The left clavicle and one finger bone were fractured. He also had a mild cerebral concussion plus multiple lacerations of the face and scalp. One thousand cubic centimeters of 5 per cent dextrose in distilled water and one unit of Dextran® were given intravenously immediately. A tracheotomy was done early the next morning. One thousand cubic centimeters of blood were given later. Hemoglobin was then 13.7 Grams and the hematocrit was 44. At 3:00 p.m., the day after admission, closed intercostal drainage was carried out with the prompt drainage of 750 cubic centimeters of bloody fluid from the left hemithorax. The hematocrit later that day was 36 in spite of the two transfusions and 33 the next day. During the next two days, two transfusions were given. The patient made a rapid recovery. The intercostal

tube was removed on the sixth day and the tracheotomy tube 3 days later. The patient was discharged on the 18th day.

Case three illustrates the use of tracheotomy in a patient with bilateral rib fractures and hemopneumothorax, who in the overall, was moderately severely injured. His recovery was materially aided by adequate fluid and blood replacement for his losses. His prompt recovery was surprising to the insurance company investigator, who talked with the author concerning this patient. From the preliminary report available to the investigator, he had expected that the patient would be dead at the time of his study of the record. Instead the patient had been discharged from the hospital. Such is the reputation of severe injuries of the thorax with multiple associated injuries. The serious prognosis of such injuries has been emphasized by Windsor and Dwyer.[6]

No mention has been made in this paper about the technic of tracheotomy. This is described in standard texts and it is by no means an innocuous procedure. The tracheotome and the cannula require meticulous and constant attention. The inner tube and the tracheotomy tube itself must be kept clear of crusted secretions. Suction of the tracheobronchial tree must be carried out at frequent intervals to keep the airway free of secretions.

Meticulous care is needed with the catheters, which must be frequently changed to prevent the introduction of bacteria to complicate the already serious condition of the patient. Oxygen, when given through the tube, must be moistened. The bronchial secretions should be collected from time to time in a Lukens bronchoscopic collection tube for culture and sensitivity determination to antibiotic drugs. Only in this way, can proper antibiotic therapy be guided. The problems of tracheotomy have been well discussed by Meade.[5]

120 West State Street

BIBLIOGRAPHY

1. Avery, E. B., Morch, E. T. and Benson, D. W.: Journal of Thoracic Surg., 32:291 (1956).
2. Brewer, L. A., Burbank, B., Samson, P. C. and Schiff, C. A.: Annals of Surgery, 123:343 (1946).
3. Carter, B. N. and Giuseffi, J.: Journal of Thoracic Surgery, 21:495 (1951).
4. Carter, B. N. and Giuseffi, J.: Surgery, Gynecology and Obstetrics, 96:55 (1953).
5. Meade, J. W.: New England Journal of Medicine, 265:519 (1961).
6. Windsor, H. M. and Dwyer, B.: *Thorax,* 16:3 (1961).

Epilepsy and the Law

Do you ever see a patient subject to periodic attacks of impaired consciousness? If so, you will want to devote Wednesday afternoon, February 20, to a symposium on epilepsy and the law.

The meeting starts at 1:30 p.m. and will be held in the Gibraltar Building at Bank Street and Broad Street in Newark. The meeting will adjourn promptly at 4:30 p.m.

Dr. Frederic Gibbs, the pioneer electroencephalographer, and a distinguished epileptologist, will open with a talk on the medical aspects of the problem. He will be followed by William Braun, of the New Jersey Bar, who will review the legal responsibilities of the physician in this area.

The third speaker, Ned Parsekian, is our State's Motor Vehicle Director. Mr. Parsekian will talk about the problem of driving licenses for epileptics. The patient's own responsibility in this area will then be reviewed by Mr. John A. Gleeson.

The meeting will conclude with a summation by Dean Roscoe L. Barrow.

This program is sponsored by the section on neurology and psychiatry of the New Jersey Academy of Medicine. Drs. Ira S. Ross and William Furst are chairman and secretary, respectively, of that section. There is no registration fee or admissions charge.

Board of Trustees

OCTOBER 21, 1962

A regular meeting of the Board of Trustees was held on Sunday, October 21. Following is a summary of the significant actions taken:

Governor's Conference on Community Nursing . . . Agreed to co-sponsor (with the New Jersey Hospital Association, the New Jersey Health Officers Association, the New Jersey Public Health Association, the New Jersey League for Nursing, and the New Jersey Welfare Council) the Governor's Conference on Community Nursing. This will be held early in 1963 . . . appointed Dr. David Eckstein as the Society's representative on the planning committee for this Conference.

Retirement Program Law . . . Requested that the Special Committee on Retirement Plan for Physicians study the new law (passed as HR-10; also known as the Keogh Bill), and promptly supply component societies with detailed information concerning physician participation in retirement programs under this law.

MSA Request for Funds . . . Considered a Medical Surgical Administration request for a grant of $5,000 to meet the operational deficit that is anticipated in the next several months. Informed MSA that this request must be referred to the next meeting of the House of Delegates because:

1) The 1959 House of Delegates had disapproved the request of MSA for a $5,000 grant and recommended that "should urgent financial need arise in the future, specific requests should be submitted to the Board of Trustees."
2) This requested sum does not represent the "urgent financial need" stipulated in the House action, since MSA controls report indicates that the $700 surplus at December 31 will cover expenses until April 1963.

Golden Merit Award . . . Adopted the recommendation of the Council on Public Relations that a social hour for Golden Merit Award recipients and their families present in Atlantic City be held in conjunction with the 1963 Annual Meeting . . . allocated a sum not to exceed $250 for that purpose.

1963 Exhibit Schedule . . . Adopted the recommendation of the Annual Meeting Committee that all exhibits and the Motion Picture Theatre open at 9:00 a.m. on Monday, May 13, and close at 1:00 p.m. on Wednesday, May 15; with installation of exhibits to take place on Sunday afternoon and evening, May 12.

1963 House of Delegates . . . Adopted the recommendation of the Annual Meeting Committee that the final session of the House of Delegates convene at 9:00 a.m. (instead of 9:30 a.m.); recess at 11:30 a.m. for two hours, to allow the delegates to visit the exhibits (instead of the 45 minute luncheon break) and eliminating the Society sponsored luncheon; and reconvene at 1:30 p.m.

The President authorized an intervening day in the schedule of the House, and instructed that officers of scientific programs originally scheduled for Tuesday be informed that their programs will be advanced to Monday.

Academy of Medicine . . . Approved the request of the Academy to present a special program at the 1963 Annual Meeting in connection with graduate teaching programs in hospitals, to be co-sponsored by MSNJ and the New Jersey State Department of Health . . . directed that one-half hour of the afternoon session be set aside for a presentation on venereal disease in New Jersey, at the request of the State Department of Health.

1964 Annual Meeting . . . Deferred until 1964—in view of the full program already scheduled for the 1963 Annual Meeting—the following requests for special programs:

1) From the State Commissioner of Health, for a special program on alcoholism;
2) From the Visiting Homemaker Services, for presentation of a special paper;
3) From the Special Committee on Disaster Medical Care, for special time for a disaster medical care program.

Constitutional Amendment Implementation . . . Approved Legal Counsel's interpretation of the appropriate section in the Bylaws governing the number of delegates to which each Society is entitled (Bylaws, Chapter I, Section 2, paragraph (c)) as follows:

> The word "recorded" is interpreted to mean of record on the 31st of December in the office of the Secretary of MSNJ. The State Secretary's records will reflect a certain number of active members for each component society, as a result of information gained by the Secretary directly or indirectly. This tally will exclude members (as of that date) who are dead, have resigned, have transferred to another state, and members who have transferred to another county within the state as of that date.
>
> Transfers within the state must be completed prior to December 31 for the physician to be counted in the membership of the new society—that is, prior to December 31, the transferring member is accepted in the new society, and the new society has notified the State Secretary that the transferring member is now an active member of its society.

First Assistants in Major Surgical Procedures . . . In response to a request from a member advised that the medical board or staff of the hospital should decide who is qualified to assist in major surgical procedures. As long as interns and residents, under the New Jersey law, have the two-year period before a license is required, any intern or resident in a hospital should be eligible to serve as first assistant at a major surgical operation if deemed qualified by the hospital medical staff or board.

The Board of Trustees directed that this request and its opinion be referred to the Medical-Hospital Liaison Committee and to the Subcommittee on Physician-Hospital Relationships.

Kerr-Mills Law . . . Directed that the AMA be informed MSNJ has no suggestions for amending the Kerr-Mills Law at federal level, but would appreciate a model outline of implementing legislation effective in other states.

Trustees Honored . . . Accepted with satisfaction a report that Dr. Joseph R. Jehl and Dr. Jerome G. Kaufman had been separately honored at testimonial dinners in their honor.

1963 Child Safety Week . . . Adopted the recommendation of the Special Committee on Child Health that the Governor be requested to proclaim the first week of April 1963 as "Child Safety Week" throughout New Jersey.

Pre-School Age Children . . . Approved the recommendation of the Special Committee on Child Health that—in accordance with the minimum standards of the State Department of Health—child health committees investigate the needs in their own communities for services for health care of pre-school children; and that at least annual physical examinations be given to all pre-school children.

Accreditation of Nursing Homes . . . Approved the action of the New Jersey Joint Council to Improve the Health Care of the Aged—through the Special Committee on the Chronically Ill and the Aging—to evolve a program for the accreditation and certification of nursing homes; and to encourage wherever possible the affiliation of nursing homes with general hospitals.

Chronically Ill and the Aging Committee . . . Approved the recommendation of the Committee that component societies be urged to establish liaison groups with the local agencies responsible for planning and establishing housing projects for the aged; and that their own committees on the chronically ill and the aging be used for this purpose. Component societies are urged to offer their committees as liaison consultants to all local "golden age" and "senior citizen" groups within their boundaries.

Fluoride Droplets or Tablets . . . Approved the action of the Council on Public Health that MSNJ reaffirm its previously adopted position of endorsement of the fluoridation of public water supply. Where this is not available, MSNJ approve in principle the use of tablets or droplets if properly controlled.

Occupational Health . . . Adopted the recommendation of the Special Committee on Industrial Health that its name be changed to "Special Committee on Occupational Health."

State Employees and Workmen's Compensation . . . Approved the report of the Special Committee that met with Deputy Attorney General Charles Levine. The fee schedule submitted by Mr. Levine for the State of New Jersey may be accepted as a *guide* for the treatment of New Jersey employees, with the following changes:

> 1) The surgical fee should not include post-operative hospital visits.
>
> 2) Where there is need for a qualified assistant, he will directly bill for his services. This should not exceed 20 per cent of the surgeon's fee. The

assistant's fee will not be allocated against the surgeon's fee for surgery.

3) Application of casts should be billed as separate procedures, with the exception of casts applied at the time of major surgical procedure.

New Jersey Welfare Council Conference . . . Appointed as MSNJ's delegates to the Conference in Asbury Park on October 30-31 and November 1 Dr. Peter J. Guthorn of Asbury Park and Dr. Albert Schmidt of Sea Girt.

Legal Liability of Physicians . . . Referred to Legal Counsel a request that he compile, for the information of the entire membership, a list of "cautions" as to what (under the laws of New Jersey) are physicians' liabilities.

Compensation of Interns and Residents . . . Instructed the New Jersey AMA Delegates to take action (at the AMA November meeting) against the special report of the AMA Council on Medical Services, in which it is recommended that interns and residents in hospitals be compensated from a fund maintained by medical staff members from fees collected from paying patients who have been assigned to the house staff by the attending physician for medical care.

Physician-Hospital Relationships

At the request of the Board of Trustees, a Subcommittee of the Council on Medical Services is engaged in a study of physician-hospital relationships in New Jersey. From this study will be developed guides and recommendations for proper relationships between the two.

The following is a summary statement of the committee's present purpose and fundamental interest. It is not a declaration of official MSNJ policy. Members are invited to send to the committee any comments and/or suggestions that they may wish to offer.

FRANCIS J. BENZ, M.D., Chairman
Subcommittee on Physician-Hospital Relationships, Council on Medical Services

There has been a gradual deterioration of the good relationship that previously existed between physicians and hospitals, not only in this state but throughout the nation. Attempts to accelerate this trend are being made by many groups, such as laymen, boards of directors, trustees, administrators, governmental agencies, employers, unions, employees, and even in some instances, by physicians and nurses. Today, there is an increasing tendency for physicians to intrude upon some of the duties and responsibilities of the hospital; and for hospitals to intrude upon some of the duties and responsibilities of physicians. The physician's primary responsibility is the care of his patient. He is the only one skilled in the art of medicine; a hospital cannot function without the direction and help of the physician. The hospital's responsibility is to furnish the necessary technical materials in the way of buildings, beds, food, medicine, equipment, environment, facilities, and personnel etc., for the care of the patient. The less one group trespasses on the other's responsibilities, the more amicable the situation will be between them, and the better the patient will be served.

Most hospitals have rules governing the hospital's duties and responsibilties, just as the medical staffs have bylaws and regulations governing the duties and responsibilities of staff members. All hospitals should have a "Joint Conference Committee" of hospital representatives to meet with a group of physicians elected by the medical staff to discuss mutual problems and to review apparent conflicts between the two groups. Even with such committees, some problems cannot be resolved; then an unfortunate situation develops that divides rather than makes for unity in the hospital.

The proper relationship of the physicians and the hospital is a multifaceted one, with ramifications extending into moral, philosophical, legal, traditional, ethical, and economic fields, to mention only a few of the important ones.

The primary purpose of the physician and the hospital is, and always will be, to render proper care to the sick and injured, a purpose which transcends all others. All other considerations must, of necessity, be kept secondary to this. This primary purpose can be, and is being fulfilled at present as it has been in the

past; but today, with the marked advances in both medicine and hospital management, the problem of fulfillment has become more complex. The physicians and the hospitals have successfully resolved this mutual problem in the past, and we are all reasonably certain that it will be successfully resolved in the future; but it will require even more mutual trust and confidence than were required in the past.

There is no place for invidiousness, invective, or detrimental accusations in this primary concern of both parties, and it behooves all of us to strive with all of our knowledge, skill, experience, and interest to attain this end amicably.

The physician, of necessity, must be conversant with and observant of all proper ethical and legal considerations, if he is to continue to deserve the high esteem that he enjoys in the opinion of his fellowmen.

Every medical doctor should be a member, not only of his county medical society and the State Medical Society, but also of the AMA. The Medical Society of New Jersey should publish a guide to be followed by the staffs of the hospitals in New Jersey. Each county medical society should have a committee to advise hospitals within the county in the development of equitable bylaws and regulations for their medical staffs.

In some instances New Jersey hospitals have written their medical staff bylaws, rules, and regulations with total disregard of the physicians. In some instances, without just cause, physicians have been denied the privilege of admitting a patient to the hospital or treating him. In other instances the physician's privileges to treat certain types of patients have been summarily limited. Not infrequently a physician's reappointment to the staff has been denied without explanation or hearing before his colleagues: his privileges and position on the staff have been adversely altered for no apparent reason, and he has had no access to any mechanism to counteract these decisions.

The hospitals are faced with the problems of some defiant physicians who apparently refuse to abide by the bylaws of the staff even though, in most instances, the bylaws permit a large range of activity and involve few severe restrictions. Most hospitals have a nucleus of a few physicians vitally interested in maintaining the standards recommended by the Joint Commission on Accreditation, but too few of the physicians are so interested.

The administrator knows that the Tissue Committee, the Credentials Committee, the Records Committee, and many other committees, are important. He is dependent upon the staff members to perform their duties on these committees and to keep accurate records of the proceedings of each committee. However, the administrator has no way to force the staff members to do so. This power should be exercised by the medical staff itself.

Many other difficulties arise, and the relationship of the physician to the hospital and of the hospital to the physician at best is a delicate one. The administration can bring undue influence to bear on the physicians through the board of directors or trustees; and in some instances the physicians can influence the board of trustees against the administrator.

We all know that these problems exist, and that there are acceptable and proved methods to deal with these different circumstances. It is the purpose of this committee to evolve and issue, with the approval of The Medical Society of New Jersey, a set of guides and principles for the realization of this end.

Salute to Old Timers

From the Cumberland County Medical Society comes this tribute. Dr. Earl C. Lyon of Bridgeton read it at the October meeting. Dr. Lyon joined the Society in October 1920. He wrote:

> At the October meeting, I observed the members present and recalled that 42 years ago today I joined the Cumberland County Medical Society. Of the 67 former members there are now only five remaining, and four of them are here now. Down through the years, these four have helped our Society through elective and appointive office, through committee work and through regular attendance. I wish to salute Dr. Mary Bacon, Dr. Samuel Day, Dr. Charles E. Sharp and Dr. James S. Knowles.

This JOURNAL joins in this tribute. Dr. Bacon has been a member since 1917; Dr. Sharp since 1916; Dr. Knowles and Dr. Day since 1912.

Disclosure by Physicians*

In 1957, this JOURNAL published an article entitled "Disclosure of Medical Information," written by this author, who will endeavor to bring up to date the question of confidentiality and privileged communication as it pertains to those licensed to practice medicine and surgery in New Jersey. In the 1957 article, it was pointed out that although in many states a privileged communication statute does exist,[1] New Jersey adheres to the progressive, though minority, view that the public welfare outweighs the right of the individual patient to have his communications to physicians free from disclosure, *i.e.*, in the absence of statutory privilege, the physician may be *required to testify* concerning such facts. The patient's right of privacy, however, does exist in this state.[2] This right has been constituted as a freedom from unwarranted publicity, and a right to be protected from any wrongful intrusion into his private life which would outrage or cause mental suffering, shame or humiliation to a person of ordinary sensibilities.[3]

It was pointed out in the 1957 article that this right of privacy is a limited one which is not always superior to the right of the public, such as the duty of witnesses to testify in matters vital to public interest.[4] And, at the time of that writing there was little or no law to guide a physician in the matter of how far he might go in disclosing to third persons details concerning his patient without invading the individual's right of privacy. Guidance in this heretofore has been obtained from the decisions of the courts of other states. It has been thought that there was adequate safety in proceeding at least as far as physicians have gone in states where privileged communications statutes are in effect and disclosure of medical details has been allowed to prevent the spread of contagious disease, when the same is done in good faith without malice and where the grounds for diagnosis are reasonable.

A recent decision of the New Jersey Supreme Court, *Hague vs. Williams,* 37 N.J. 328, 181 A2d 345, now presents us with new guidance without defining the extreme limitations of the exceptions to the rule that a physician should not disclose information concerning his patient's health absent that patient's consent. In that case it was determined that the conditions for disclosure are sufficiently compelling where the physical condition of the patient is made an element of an insurance claim. Knowledge of an infant's pathologic heart condition, as an example, obtained by a physician in the normal course of consultation or treatment is not of such confidential nature that a physician is barred from extra judicial disclosure of that fact to an insurer to whom his parents applied for life insurance on the child. At the time of such application the parents are treated as having waived any right of nondisclosure they might have had. Other than the above case, however, there appears to be no further aid for the physician in determining from an examination of the facts in each case on their individual merits, whether or not he is going too far in disclosing to third persons details concerning his patient without invading that patient's right of privacy.

The underlying guiding principle remains that the right of the patient is a *limited* right against disclosure, and although a physician ordinarily receives information relating to one's health in a confidential capacity, he *may* legally disclose the same without the patient's consent where the public interest or the private interest of the patient so demands.

ROBERT M. BACKES

*This article was prepared by Robert M. Backes, LL.B., our Society's Legal Counsel and is here published by direction of the Board of Trustees.

(1) Thirty-one states have confidential communications statutes designed to protect the patient against disclosure, except upon consent. New Jersey is not one of these states.
(2) *Frey vs. Dixon,* 58 A2d 86, 141 N.J. Eq. 481. "A right to privacy exists in New Jersey."
(3) *McGovern vs. Van Riper,* 54 A2d 469, 140 N.J. Eq. 341.
(4) *McGovern vs. Van Riper, supra*: "The right of privacy has its limitations and is not always superior to the right of the public, but must be construed in the light of an individual's relation to the community of which he is a member."

Sports Medicine Newsletter Available to Physicians

"Medicine in Sports," a newsletter devoted to the care and prevention of athletic injuries, is now distributed to all interested physicians. Send your request to "Medicine in Sports," 7 North MacQueston Parkway, Mount Vernon, N. Y. This newsletter fills the gap created by the rapidly growing interest in sports medicine. While many professional journals cover the subject intermittently, "Medicine in Sports" regularly provides rapid summaries, coverage of meetings and symposia, and exclusive articles by authorities.

"Strike Back at Arthritis"*

The New Jersey Department of Health initiated an arthritis program in 1958. One of its 1961 activities was the distribution of the booklet,[1] "Strike Back at Arthritis," prepared jointly by the U.S. Public Health Service and the Arthritis and Rheumatism Foundation. Our Advisory Council had recommended that the booklet be made available to all physicians and hospitals. The New Jersey Chapter of the Arthritis and Rheumatism Foundation cooperated in this activity.

An initial letter announcing the booklet was mailed June 11, 1961, to the 8,183 physicians licensed in New Jersey. Enclosed with the letter was a leaflet[2] called "An Aid to Preventing Deformities in Arthritis," prepared by The Arthritis and Rheumatism Foundation; and a franked postcard addressed to the Division of Chronic Disease Control, New Jersey State Department of Health, the reverse side of which read:

> "Kindly send me a copy of the booklet, 'Strike Back at Arthritis,' for use with my arthritis patients."

The card response began within a few days of the mailing and continued at a high level for three weeks, tapering off over the next three weeks; sporadic cards were received over the ensuing 12 months for a final total of 2,137 in May 1962. Analysis of 2,107 responses was made (30 being indecipherable).

Doctors of both medicine and osteopathy are licensed to practice medicine in New Jersey. The number of osteopaths who returned cards represents a larger proportion of their total membership (40 per cent) than does the number of responses from the doctors of medicine (25 per cent). See Table 1.

Table 2 shows the distribution of New Jersey physicians by specialty, and the number of respondents in each category.

The largest physician-response was received from the general practitioners and internists. General practitioners formed 42 per cent of the total number of doctors of medicine responding; 68 per cent of the doctors of osteopathy. A check with the specialty listings of the American Medical Association[3] for New Jersey indicated that 30 per cent of general practitioners in the state (M.D.s) and 35 per cent of internists (M.D.s) were among the respondents. Orthopedists showed a high proportion of replies—34 per cent. Unexpectedly large responses were received from those classified as "eye-ear-nose-throat" (39 per cent), cardiologists (26 per cent), allergists (26 per cent), and psychiatrists (23 per cent). Perhaps these latter categories of physicians do not limit their practices strictly.†

TABLE 1.

NEW JERSEY PHYSICIANS' RESPONSE TO "STRIKE BACK AT ARTHRITIS" BOOKLET

Total New Jersey physicians who were sent announcement		8183
Doctors of Medicine	7687 (94%)	
Doctors of Osteopathy	496 (6%)	
Total New Jersey physicians responding		2107
Discarded as illegible or undecipherable		30
Doctors of Medicine	1907 (91%)	
Doctors of Osteopathy	200 (9%)	
Per cent of New Jersey physicians responding		26%
Doctors of Medicine	25%	
Doctors of Osteopathy	40%	

1. "Strike Back at Arthritis" Public Health Service Publication No. 747. For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Price 40 cents.

2. "An Aid to Preventing Deformities in Arthritis," Arthritis and Rheumatism Foundation, 10 Columbus Circle, New York 19, New York.

3. AMA Directory Report Service. Quarterly Tables for Distribution of Physicians by type of practice. July 1961. Department of Circulation and Records, American Medical Association, Chicago.

†With respect to psychiatrists, the editor must disagree with this presumption. There are emotional factors in the arthritis cycle, and it is not surprising that many psychiatrists showed interest in this booklet. Such interest does not indicate any failure to limit practice to psychiatry.

*This article was prepared by Margaret Hay Edwards, M.D., M.P.H. Dr. Edwards at that time was Coordinator of our State Health Department's arthritis program. Her present address is: Diabetes and Arthritis Program, Division of Chronic Diseases, Public Health Service, Washington 25, D.C.

SUMMARY

Twenty-five per cent of the physicians licensed to practice in New Jersey responded to the offer of an educational booklet for use with arthritis patients entitled, "Strike Back at Arthritis." Analysis of respondents indicated particular interest in the material among general practitioners, internists and surgeons, with relatively high responses from otolaryngologists, orthopedists, cardiologists, allergists and psychiatrists.

TABLE 2.

NEW JERSEY PHYSICIANS' RESPONSE TO "STRIKE BACK AT ARTHRITIS" BOOKLET BY SPECIALTY

	Osteopaths Who Responded		M.D.s Who Responded		Total M.D.s in New Jersey by Specialty		M.D. Respondents as % M.D.s in New Jersey By Specialty
Specialty	D.O.s	%	M.D.s	%	Total	%	%
General practice	136	68.0	802	42.1	2706	35.2	29.6
Internal medicine	11	5.5	320	16.8	915	11.9	35.0
Surgery	4	2.0	174	9.1	817	10.6	21.3
Manipulative therapy	14	7.0	..	..	..	..	..
Obstetrics, gynecology	2	1.0	73	3.8	577	7.5	12.7
Orthopedics	2	1.0	68	3.6	202	2.6	33.7
Psychiatry	2	1.0	62	3.2	263	3.4	23.6
Pediatrics	..	..	51	2.7	420	5.5	12.1
E.E.N.T.	1	0.5	35	1.8	90	1.2	38.9
Radiology	4	2.0	31	1.6	172	2.2	18.0
Anesthesiology	1	0.5	30	1.6	245	3.2	12.2
Ophthalmology			24	1.3	196	2.6	12.2
Industrial medicine	3	1.5	24	1.3	125	1.6	19.2
Urology			16	0.8	151	2.0	10.6
Cardiology			15	0.8	58	0.8	25.9
Dermatology			14	0.7	115	1.5	12.2
Pathology			12	0.6	126	1.6	9.5
Allergy			10	0.5	39	0.5	25.6
Physical medicine and rehabilitation			3	0.2	18	0.2	16.7
Other	20	10.0	143	7.5	452	5.9	31.6
Totals	200	100.0	1907	100.0	7687	100.0	24.8

New Medical Bibliography Available

The National Library of Medicine announces the publication of the *Bibliography of Medical Reviews, Cumulation,* 1955-1961. This supersedes volumes published during the past five years, and lists 3,300 additional review articles not previously indexed. The cumulation, containing 21,000 subject entries for 13,500 review articles collected from 1,949 journal titles over a six-year period, has been edited to conform to the style used in the *Index Medicus.*

In addition to the subject index, there is a roster of journals indexed and a prefatory article *"The Review Literature of Medicine."*

The volume is available from the Superintendent of Documents, Government Printing Office, Washington 25, D.C., at $3.50 per copy.

Announcements • • •

Metabolism Lectures at Somerville

You are invited to attend a lecture on pediatric aspects of dietetics and electrolytic management to be given at the Somerset Hospital in Somerville at 4:30 p.m., January 17. Then at 4:30 p.m. on February 14, you can hear a talk by Rachmiele Levine, M.D. (Chairman of Medicine, New York College of Medicine) on therapy of insulin.

Otosclerosis and Tympanoplasty

A one week graduate course in the microsurgery of otosclerosis and in tympanoplasty is announced beginning February 11, 1962 at the Temple University Medical Center, Broad and Ontario Streets, Philadelphia. For details, write to Dr. Bernard J. Ronis of the Otorhinology Department of Temple University Medical Center, Philadelphia 40, Penna.

Interested in Psychiatric Studies?

The Essex County Overbrook Hospital is planning to develop lecture and seminar programs in drug therapy in psychiatry, in ego psychology, in continuous case seminars and in dynamic psychiatry. If interested, write to Dr. Allen Welkind at 638 Prospect Street, Maplewood. The meetings will probably be held in Cedar Grove, near Montclair.

Help for Alcoholics

The State Health Department has a list of physicians available to advise medical staffs, individual doctors, hospitals, clinics and associations of professional people on problems relating to alcoholism. Some give talks on alcoholism before medical meetings. They can help plan training programs for interns, residents, family doctors, and nurses. They can provide assistance in the management of the indigent alcoholic.

To utilize these resources, write to the Commissioner of Health, Trenton 25, N. J.

Ophthalmology Lecture

Professor A. Bangerter, Chief of the Eye Clinic, St. Gallen, Switzerland, will deliver five lectures March 11 to 15, 1963, under the auspices of the Institute of Ophthalmology of the Americas. He will discuss functional visual and the correlative disturbances; pleoptics; orthoptics; the presentation and treatment of amblyopia after the "St. Gall Method"; squint surgery; and disturbances of lacrimal drainage. Inquiries regarding registration may be addressed to Registrar, Institute of Ophthalmology, Eye and Ear Infirmary, 218 Second Avenue, New York 3, N. Y.

Multiple Sclerosis Pamphlet Available

A clear, but correct exposition of what we know—and don't know—about multiple sclerosis is available in Public Affairs Pamphlet Number 335. Available for 25 cents from the Public Affairs Committee (22 East 38 Street, New York 16, N. Y.), this 28-page booklet reviews the pathology of this disease and what research has, and can hope to accomplish. It will interest the family of every multiple sclerosis patient, and may help dispel their despair without arousing false hopes.

New Psychiatry Professor at Seton Hall

Dr. Harry A. LaBurt has been named clinical professor of psychiatry and acting chairman of the department at Seton Hall College of Medicine. Born in Pennsylvania in 1898, Dr. LaBurt has, for many years, been in the New York State Hospital system and, until this year, was superintendent of the Creedmoor State Hospital in Long Island. Dr. LaBurt received his M.D. at the University of Buffalo in 1923. He is one of the editors of the American Journal of Psychopathology. During World War I he was an Air Cadet and during World War II he served on a draft board. In disclosing this appointment, Dean McCormack pointed out that "Dr. LaBurt will limit his activities to academic medicine, and perform no duties on the psychiatry service of the Jersey City Medical Center."

Letters to The Journal • • •

Fluoridated Water and Blood Glucose

Dear Sir:

A member in southern New Jersey asked us about the effect of fluoridated water on blood glucose. The answer is this: drinking fluoridated water will cause no rise in the level of the blood fluoride and no appreciable alteration of the fluoride content of soft tissue.[1] Venous blood (collected from patients for the determination of blood glucose) is frequently collected in tubes containing sodium fluoride. The final concentration of sodium fluoride in these tubes is ten milligrams in one cubic centimeter of blood. Kantor and Wilkerson[2] have shown that sodium fluoride can preserve blood for the biochemical determination of glucose at this concentration. There is a minor change in the concentration of blood glucose after four days at room temperature using this method.

Incidentally, the incidence of diabetes mellitus is not increased in persons drinking fluoridated water.[3]

ELLIOTT S. WOLFE, M.D.
Diabetes Control Program, USPHS

Nicotine Addition

Dear Sir:

May I comment on your first-rate editorial "Smoking and Our Mouth Centered World," which appears in the November 1962 JOURNAL? I must disagree with your statement "A cigarette . . . does not enslave the smoker the way opiates hook the addict." Over the past 25 years I have observed patients who gave up smoking and then could not carry on a livelihood, unless the craving for tobacco was satisfied. Recently, I treated a confused salesman, taken off smoking because of bronchial asthma, who told me he had lost a $10,000 commission because he could not present the facts to his prospect.

Fortunately, I would guess that only one or two of every 100 smokers are addicts. When you consider the number of smokers, this small percentage adds up.

In an article* which appeared in this JOURNAL nine years ago, we reported the results of a questionnaire answered by 1491 physicians in New Jersey: 61 per cent of our members were smokers. Of these, 46 per cent gave their main reason for enjoying smoking, "relieves tension." Of the same group of smokers, 56 per cent said they especially enjoyed smoking after meals.

So this would tie in with your thoughts of orality —the infant seeking the nipple at the breast—the small child with his thumb in his mouth.

FRANK L. ROSEN, M.D.

Editor's Note. Our favorite psychiatrist (name available on request) tells us that the criterion of an addict is the withdrawal syndrome. The tensions suffered by the newly reformed smoker are not in the same league as the painful, fever-producing, diarrhea-developing, body-drenching syndrome of withdrawal that is the hall-mark of early abstinence by the narcotic addict. It is a matter of definition. In a sense, a passion for candy, golf, card-playing or sun-bathing is a kind of "addiction" too; but clearly not to be spoken of in the same bracket as habituation to opiates.—Editor.

M.D.'s Responsibility for Auto Accidents

Dear Sir:

Recent court action resulted in a $269,000 liability settlement against a doctor for not reporting a case of epilepsy. Epilepsy is reportable under the State Sanitary Code, Chapter II, Regulation 1 and 2. Failure to comply to the Sanitary Code, devised to protect the public from communicable disease, made this doctor liable for an automobile accident. The enforcement of the Sanitary Code in this fashion will drive epileptics away from proper medical treatment and load our highways with improperly treated people who simply lie on their applications for licenses. The health of the patient should be the doctor's responsibility. The issuance of drivers' licenses to hazardous drivers should be, and by right ought to be, the responsibility of the agency issuing the license to drive. It is up to the doctors in this state to ensure that the law is so revised that no treating physician can again be held liable on so tenuous a responsibility.

IRA S. ROSS, M.D.

*Journal of The Medical Society of New Jersey, 51:344 (August) 1954.

1. McClure, F. J. and Zipkin, I.: *Fluoride Drinking Waters*, a 1962 publication of the U.S. Department of Health, Education and Welfare: pages 354-61.

2. Kanton, N. and Wilkerson, H.: *Diabetes*, 6:176, (February 1957).

3. Elwells, K. and Easlick, K.: *Classification of Objections to Fluoridation*, a 1960 publication of the University of Michigan; page 7.

Obituaries • • •

DR. JOHN B. BOYD

One of Monmouth County's best know practitioners, Dr. John Blair Boyd, died on October 22. Born in Jersey City in 1892, he received his M.D. at Bellevue in 1914. Dr. Boyd was one of the founders of Riverview Hospital in Red Bank and was its first chief of staff. He recently completed a three-year tour of duty as president of that hospital's medical board. He also had some years as senior surgeon to the Red Bank Police Department. An FACS, Dr. Boyd was particularly interested in traumatic surgery, and was active in the American Fracture Association. He was the only New Jersey member of the "Trauma Committee" of the New York Medical Society. Dr. Boyd had also done considerable committee work for the American Association of Railroad Surgeons.

DR. JAMES F. CLARK

At the untimely age of 42, death came on November 6, 1962 to Dr. James F. Clark, a Red Bank ophthalmologist. Dr. Clark was born in New Hampshire. After receiving a B.S. at the University of New Hampshire in 1941 he served in the Army; and in 1945 entered Long Island College of Medicine. In 1949 he received his M.D. and at the conclusion of his internship, accepted an ophthalmologic residency at Kings County Hospital in Brooklyn. Finishing this in 1953 he moved to Monmouth County where he entered the private practice of ophthalmology. He was affiliated with the Monmouth Memorial, Riverview, Fitkin and Bound Brook Hospitals and was active in committee work with the Monmouth County Medical Society.

DR. SANTE GIAMBRA

A heart attack on the golf course took the life of Dr. Sante Giambra on November 7, 1962. Born in Italy, he came to this country in childhood and in 1919 matriculated at the Jefferson Medical College, receiving his M.D. in 1923. He did general practice in Paterson with special attention to gynecology and surgery. He became Associate Gynecologist at Paterson General and Visiting Surgeon at Hope Dell. A year ago he had a stroke and retired from practice but improved sufficiently to take active part in civic and social activities in Paterson and Glen Rock. A Fellow of the International College of Surgeons, he was also active in the affairs of the Passic County Medical Society.

DR. PHILLIP M. JOFFE

Death came on November 19, 1962, to Dr. Phillip Mr. Joffe, a Paterson internist. Dr. Joffe was 54 years old at the time of his death, which occurred at the Massachusetts General Hospital in Boston. Dr. Joffe earned his M.D. at Bellevue in 1932 and won an internship there. After completing his internship, he remained as a house physician for graduate work in internal medicine. He became affiliated with the faculty of the medical school at New York University. During World War II, he was a major in the Army Medical Corps. Dr. Joffe was Attending Physician at the Barnert Memorial Hospital in Paterson. He was active in the affairs of the Passaic County Medical Society.

DR. FRED A. KESSLER

On November 14, 1962, a heart attack took the life of Dr. Fred Anthony Kessler, a Woodbridge cardiologist. Dr. Kessler was born in Vienna in 1898 and received his M.D. at the University there in 1923. Until 1930, he was a staff resident at the *Allegemeine Krankenhaus* in Vienna. In 1931 he came to the United States, settled in Middlesex County, New Jersey and became affiliated with the Perth Amboy General Hospital. He was also school doctor for Woodbridge Township and made his home in that community. He was a Fellow of the American College of Cardiology.

DR. SAMUEL J. MARGOLIN

At the untimely age of 55, Dr. Samuel J. Margolin, a Hudson County surgeon, died suddenly at the Christ Hospital in Jersey City. A 1934 graduate of the medical school of Duke University, Dr. Margolin moved to North Bergen in 1938 and had been serving the people of that area ever since. He was affiliated with the North Hudson Hospital and with the Christ Hospital, and was active in the affairs of the Hudson County Medical Society.

DR. HAROLD PERLBERG

A half century of active and pioneering medical practice came to a close on October 31, with the death that day of Dr. Harry J. Perlberg. Born in 1890, he earned his M.D. at Long Island at the

age of 21. He interned at the Jersey City Medical Center and then opened an office for private practice in the thinly populated but rapidly growing Greenville section. He did general practice until 1917, and then entered the Army. In the medical corps he had occasion to work in radiology, and elected to make this his specialty. After graduate study in x-ray, he limited his practice to that field. Dr. Perlberg had a tour of duty as president of our Hudson County Medical Society. He was a Fellow of the American College of Radiology, and had been president of Red Cross in Jersey City.

DR. FRANCIS O. PFAFF

At the untimely age of 50, Dr. Francis Pfaff died on November 13, 1962 at the Holy Name Hospital in Teaneck, where he was Associate Anesthesiologist. Born in upstate New York, he received his M.D. in 1936 at Cornell. He was in the medical corps of the Army of the United States during World War II. A diplomate of the American Board of Anesthesiology, he was director of anesthesiology at Bergen Pines in Paramus. Dr. Pfaff was a resident of Teaneck and was active in the affairs of the Bergen County Medical Society.

DR. WILLIAM A. PINDAR

At the untimely age of 50, Dr. William A. Pindar died on October 29 at his home in Bergenfield. Dr. Pindar received his M.D. at Bellevue in 1939 and then interned at St. Vincent's Hospital in New York City. In 1942 he was commissioned in the U.S. Army, later in the Air Force. On being mustered out, he won a surgical residency at St. Vincent's Hospital, New York City, and in 1948, entered private practice in Bergenfield. He became affiliated with Holy Name Hospital in Teaneck and was active in the affairs of the Bergen County Medical Society. He was also surgeon to the Bergenfield Fire Department.

DR. HENRY L. SINEXON

Dr. Henry Sinexon, a veteran Gloucester County practitioner, died on November 12, 1962 at the age of 76. Dr. Sinexon had served the people of south Jersey for more than half a century. He was a 1908 graduate of the Philadelphia Medico-Chirurgical College. Dr. Sinexon was a civic and organizational leader. He had been president of the Gloucester County Medical Society. He was a director of the Paulsboro National Bank. He was one of the founders of his local Kiwanis Club and served a tour of duty as chief of the Paulsboro Fire Company. He was a general practitioner, particularly interested in geriatrics.

DR. CARL M. WINTER

On November 11, 1962, Dr. Carl Winter suffered a fatal heart attack while playing golf at his country club. Dr. Winter was born in Brooklyn in 1908 and received his M.D. at the Royal College of Edinburgh, Scotland. He was particularly interested in gynecology and obstetrics, and was on the active obstetrical service at the West Jersey Hospital. Dr. Winter practiced in Camden and Haddonfield and was a Fellow of the American College of Surgeons.

ACCP Statement on Cigarette Smoking

The American College of Chest Physicians has been studying the effect of cigarette smoking on the pulmonary and cardiovascular systems. The Regents of the College are now convinced that sufficient evidence has been accumulated to warrant an official statement. Accordingly, a resolution connecting cigarette smoking with certain pulmonary and cardiovascular conditions was approved by the Board and issued by the College.

The resolution stated that the weight of scientific evidence indicates that cigarette smoking and the inhalation of other atmospheric pollutants have a relationship which strongly suggests a causal connection with chronic bronchitis, pulmonary emphysema, cor pulmonale, cardiovascular diseases, and cancer of the lung. The College urged all physicians to intensify their educational campaign relative to the hazards of smoking. The College also encouraged efforts to control atmospheric pollution and supports research for additional information concerning other possible etiologic agents.

Book Reviews

Drugs in Current Use 1962. By Walter Modell, M.D. New York, 1962, Springer Publishing Company. Pp. 152. ($2.25)

Here is an excellent reference for many new and old drugs. They are listed alphabetically with a clear description of each including indications, side-effects and toxicities. The inclusion of proprietary and generic names makes identification simple and accurate. The description of drugs advertised on radio and television is enlightening. For example: How many realize that Nytol® is an antihistamine?

Some sulfonamides are included but the older and more toxic ones are omitted. Perhaps the author wished to evade legal complications. However, a few physicians still prescribe these older sulfonamides. For this reason, they should have been included as a precaution.

Unfortunately omitted is colchicine for intravenous use for patients unable to take it orally for gout. Bile salts and bile acids are mentioned too briefly. If the drugs were grouped according to classification, such as antibiotics, vitamins, etc., one could more readily decide which he preferred.

The author is well qualified in his discipline, and his book is compact, inexpensive and small enough to be carried in a coat pocket.

PASQUALE E. NAPPI, M.D.

Williams' Obstetrics. Edited by N. Eastman, M.D. and L. Hellman, M.D. New York, 1961, Appleton-Century-Crofts. Edition 12. Pp. 1200 with 666 illustrations. ($16.00)

The latest edition of this respected textbook of obstetrics loses none of its former comprehensiveness and adds a new dimension to its already rich background of clinical experience. To the wealth of material compiled through the years by previous authors from the Johns Hopkins and New York Lying-In Hospitals, Dr. Hellman has added large recent significant surveys from a third large institution, Kings County Hospital.

This text has always presented the most thorough textbook discussion available of embryology, and maternal and materno-fetal physiology of pregnancy with its experimental and theoretical background. This edition revises this material in light of recent information including endocrinologic aspects.

Discussion of the syndrome of habitual abortion has been expanded to include discussion of the "incompetent cervix" with accompanying illustrations. The section on dystocia from uterine dysfunction has been reorganized and clearly presented in light of recent work on uterine physiology, giving more clear cut guides for clinical evaluation and management. One significant addition is a review of available contraceptive technics and their effectiveness, including calculations of "pregnancy rates."

Because this is a text intended for students as well as practitioners, details of obstetrical problems and management are naturally not elaborated but can be found by the clinician in other works. The basic text is unchanged but modernized. As an up-to-date review and extensive reference volume its stature and its value to the practitioner remain eminent.

J. B. SKELTON, M.D.

The "Mad" Philosopher, Auguste Comte. By Boris Sokoloff, M.D. New York, 1962, Vantage Press, Inc. Pp. 186. ($3.00)

Auguste Comte was in a real sense a product of his time (1798-1857). No period in history was jarred more frequently or more thoroughly by social and political upheaval. With the destruction of the *ancien régime* and the enthronement of Reason came the denial of revealed religion and its replacement by the cult of science. Comte's master, Saint-Simon refused to admit even the moral standards of religion into the new libertarian society. Yet, prophetically enough, this same Saint-Simon, half-blinded as a result of a suicide attempt, admitted shortly before his death that "Religion cannot disappear from the world; it can only change." This belated reaffirmation of faith brought to an end the long collaboration between him and Comte.

In defiance of even the liberal French mores, Comte lived with a prostitute whom he later married as a gesture of contempt for the authorities. When she returned to a more affluent lover, Comte promptly developed symptoms of paranoia, followed by a severe depression. Like the master he had disavowed, he made a futile suicide attempt. Comte treated his poor wife like a beast of burden, and after fourteen years of wretched coexistence sent her packing when an attack of smallpox had blighted her once-beautiful complexion.

Two years later, Comte met the second woman in his life. Playing on the sympathies of a weak and ailing girl of nineteen, he whined his way toward her surrender by accusing her of wrecking his nervous system through a cruel and unnatural chastity. Although Positivism had declared

the marriage bond indissoluble Comte dangled the enticement of marriage and maternity before this newly found hand-maiden. It was only the death of Clotilde which brought to an end this travesty of wooing. Naturally there followed another period of profound depression and self-pity. In remorseful devotion to the memory of the saintly departed, Comte now formulated a new religious cult surcharged with the very emotionalism he had previously disdained. A compulsive repetition of daily prayers and weekly visits to the cemetery of Pere-Lachaise were parts of the weird ritual to which he adhered for the rest of his life. Now Comte said that: "Woman as wife and mother has a great mission, for the worship of a woman is a preparation for the worship of humanity." It is difficult to reconcile this newly found love for humanity with the cold intellectualism of earlier days. But whether or not, it was this love for the masses as expressed in the "Positive Polity" which became the central theme in the newly-organized science of Sociology.

Attempting to define Comte's complex personality in terms of modern psychodynamics Sokoloff tells us that his strong mother-love complex, repressed during the years with Caroline, was finally re-awakened through the more spiritual love for Clotilde, and guided him at long last to "religion, sensual and warm and idealistic to a great degree." Whether this will explain the exhibitionism, egocentricity, jealousy, and downright cruelty which marked his early life each reader must decide for himself. Apparently, genius by definition implies a non-conformity which is inscrutable and unpredictable.

We can be grateful to Dr. Sokoloff for rescuing this commanding figure from behind the mass of his writings into the light of our comprehension. It is reassuring to find that even so gifted a creature (whose purely intellectual vision was dazzled for years by the brilliance of his own creativity) could be restored through the power of love into compassionate communion with the masses of his fellow-men.

Morris H. Saffron, M.D.

Diagnosis and Therapy of the Glaucomas. Bernard Becker, M.D. and R. N. Shaffer, M.D. St. Louis, 1961, Mosby. Pp. 359 with 235 illustrations. ($18.00)

This book should be constantly available to the practicing ophthalmologist. It makes an excellent companion to the *Symposium on Glaucoma* published in 1959. And, surprisingly enough, there is sufficient new and different material in this book to justify its place in the library. This volume grants to the reader a decent amount of basic knowledge of the subject so that an inordinate amount of time is not spent on many things which really should be known by the practitioner. Yet, in these brief and well-written passages are to be found many gems, gleaned only by careful reading. The section on surgical technics is particularly good and is enhanced by excellent illustrations.

Emphasis is placed on the role of gonioscopy and tonography in glaucoma. Tonography is discussed at length: its place in diagnosis, prognosis, indication for operation. There is an emphatic word of warning to those who place too much emphasis on tonography's place in the decision to operate. Perhaps the most fascinating section of the book is that on "examples of tonograms." Here can be found convincing evidence of the place of tonography in diagnosis, provocative tests, adequate control, effectiveness of surgery. Careful study of these tonograms will be very rewarding. If only for that one section, I would strongly recommend this book to the ophthalmologist's attention and concentration.

S. Jerome Greenfield, M.D.

Atlas of Clinical Endocrinology. H. Lisser, M.D. and Roberto F. Escamilla, M.D. St. Louis, 1962, The C. V. Mosby Company. 2nd ed. Pp. 472. ($23.00)

This pictorial approach to clinical endocrinology has impressed your reviewer as the outstanding feature of this book. Rarely will one find a finer collection of illustrations of the typical endocrinopathies and its many variants. Thumbnail word sketches of typical clinical pictures start each chapter. The individually illustrated cases also have detailed notes of pertinent findings and treatment opposite each plate.

Diabetes mellitus, although a true endocrine disorder, has been omitted, the authors say, because "it does not lend itself to graphic presentation." Your reviewer cannot entirely agree with this. There are possibilities of illustrations of retinopathies, dwarfism of the Mauriac type, renal micropathology, and so on. However, this choice is partly compensated in interest by the inclusion of a host of conditions simulating endocrinopathies which are instructively assembled in a chapter of their own. They include progeria, mongolism, Lawrence-Moon-Biedl syndrome, Marfan's syndrome, achondroplasia and gargoylism, among others. The same care in outlining the syndromes at the beginning of each chapter is carried through and the same annotations as for the endocrinopathies are appended to the illustrative plates. Further to compensate for the omission of diabetes mellitus variants of the typical endocrine syndromes, such as Chiarri-Frommel syndrome of persistent galactorrhea, amenorrhea and pituitary dysfunction are included.

If the reader is looking for theoretical discus-

sion and clinical chemistry he will not find it in this book. Details on diagnostic laboratory tests are not included but the tests are listed. There is reference to diabetes insipidus in clear schematic and microscopic findings in the neuro-hypophysis and a genealogic chart of one family with nephrogenic diabetes insipidus. Differential diagnoses are well listed under each clinical syndrome.

Although this reviewer did not see the first edition, the chapters on hyperthyroidism and primary aldosteronism suggest careful attention to timely revisions. Texts or wide reviews on subjects can rarely be complete to everyone's satisfaction; but if a book supplies the first hand knowledge and dedicated interest of the authors then it is bound to be a worthy addition which this one would be to the library of the endocrinologist and internist.

EVERETT O. BAUMAN, M.D.

Women and Fatigue. Marion Hilliard, M.D. New York, 1962, Pocket Books, Inc. (Reprint of 1960). Pp. 150. ($0.50)

Here is an inexpensive, highly readable pocket book of the genus "Tell Me, Doctor," by a Canadian woman physician. It deals sympathetically with the stresses and strains of the average woman's life: the adolescent, the bride, the young mother, the menopausal years, and the later years. Dr. Hilliard discusses attitudes and adjustments to circumstances, and tries to explain the "why" of chronic fatigue in the light of constitutional make up, and mental approach to the problems of daily living. The only criticism which I can make is that, while mentioned casually in passing, not enough emphasis is placed on the importance of ruling out organic illness. Granted that the harrassed young mother of three preschool children is overworked and mentally stagnant, she may still have an anemia or a low grade infection, which will not respond solely to psychosomatic therapy.

Aside from this, there are many women to whom the doctor can recommend this book, either to supplement his own diagnosis, or possibly to tell her what she will not accept from him.

ZELDA I. MARKS, M.D.

Current Therapy 1962. Edited by Howard F. Conn, M.D. Philadelphia, 1962, Saunders. Pp. 790. ($12.50)

According to a recent survey by *Medical Economics*, the aspect of practice which doctors found most enchanting was diagnosis. This was seen as a titillating intellectual puzzle. However, the duty of the physician is to heal, solace or relieve; and in the last analysis treatment is the aim of all medicine. As a ready reference guide here is a book carrying compact monographs by 150 different practitioners detailing the "how to do it" of treatment. Each regime is personalized as the treatment method of—naming the author. The book has several other interesting features. In the end paper is a tabulation of normal laboratory and clinical values so that you can find in a hurry what the normal clot retraction time or normal pyruvic acid plasma concentration is. A 35-page monograph on toxicology includes the addresses of poison control centers in every part of the United States and Canada. You are also told what poisonous ingredients may be found in what household items including cosmetics and detergents. Then there is a large "roster of drugs" enabling you to check trade name against principal generic ingredients. Also included is a review of pediatric posology, and several handy conversion tables. All told, this is a veritable one-book library on the practice of medicine.

ULYSSES M. FRANK, M.D.

Psychoanalysis and Religion. Gregory Zilboorg, M.D. New York, 1962, Farrar, Straus and Cudahay. Pp. 243. ($4.50)

Psychoanalysis is supposed to be hostile to religion. Five reasons are given: Freud's personal antireligious bias; psychoanalysis' concern with sex; the competitiveness of the analytic session with pastoral confession; the assumption (by many analysts) that religious ritual is an obsession and religious faith a neurosis; and the analyst's refusal to make value judgment in terms of good and evil. Zilboorg feels that these are not serious obstacles to a rapprochment between religion and psychoanalysis. Freud's personal bias, he thinks, was due to Freud's own life experience and need not affect the entire analytic doctrine. Confession reveals conscious material not unconscious ones, and thus is different from an analytic session. The alleged overconcern with sex is based on a misunderstanding of the freudian concepts of libido and the genital stage. Zilboorg says these refer to life energies in general and altruistic love in particular and have no necessary sexual connotation in the traditional sense. As to the analyst's characterization of religion as a neurosis—well, here Zilboorg feels, the analyst is just wrong, and he says that this item can be rejected without contaminating the entire analytic doctrine.

The book consists of eleven essays collected by Zilboorg's widow. There is much to disagree with here, but the material is interesting, thought-provoking and ably defended. The lack of an index reduces the usefulness of the book.

HERBERT BOEHM, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

JANUARY, 1963 • VOL. XXXVI, NO 1

SPONTANEOUS PNEUMOTHORAX COMPLICATING CAVITARY TUBERCULOSIS

Catheter drainage and suction are recommended in the treatment of spontaneous pneumothorax in tuberculous patients as well as in nontuberculous patients. In this serious complication, immediate treatment is important, but the need for immediate resection is rare.

Spontaneous pneumothorax, an important and dangerous complication of pulmonary tuberculosis occurring in from 1 to 3 per cent of hospitalized tuberculous patients, requires immediate treatment.

While the accepted treatment of a nontuberculous patient with spontaneous pneumothorax is prompt catheter suction and drainage, it had seemed to us that pneumothorax resulting from a rupture of a tuberculous lesion might best be treated in certain instances by immediate pulmonary resection. The present study was initially begun to test this theory, but since almost all of the patients seen had bilateral disease, they were considered unsuitable for immediate resection.

We were agreeably surprised to find that the results of immediate catheter drainage and suction were good and the possible indications for immediate resection rare.

In the series were 28 patients with active tuberculosis and spontaneous pneumothorax. Eleven of these patients were treated without catheter drainage prior to our involvement in 1956. Seventeen have been treated since that time with catheter drainage.

Of the 28 patients, 20 were admitted to the Tuberculosis Sanatorium of the Baltimore City Hospitals with spontaneous pneumothorax and tuberculosis, eight developed pneumothoraces in the hospital while under medical therapy. The age ranged from 15 to 64 years.

ONSET OF PNEUMOTHORAX

The onset of spontaneous pneumothorax is usually marked by pain and dyspnea. One patient reported to the hospital with the sudden onset of weakness. The pain pattern was mostly pleuritic and on the side of the pneumothorax. Two women, who complained of severe pain and only minimal shortness of breath, stated that the pain was chiefly abdominal and knife-like. Eight patients with developed pneumothoraces were admitted in whom history of onset could not be elicited. They came to the hospital for fever, cough, and generalized weakness. X-ray examination on admission usually showed a hydropneumothorax.

The probable onset of spontaneous pneumothorax in the 20 patients admitted with the condition was from three hours to nine months prior to admission. The time of onset in the eight patients who developed pneumothorax in the hospital varied from 10 days to five months after admission, the occurrence more often being early than late. Three patients had spontaneous pneumothoraces occurring successively on the two sides. In one of these there was some overlap which required the use of chest tubes in both sides simultaneously. All three patients recovered.

ROBERT J. WILDER, M.D.; EDMUND G. BEACHAM, M.D.; and MARK M. RAVITCH, M.D.; *The Journal of Thoracic and Cardiovascular Surgery*, May, 1962.

All of these patients were treated with antimicrobials consisting of combinations of isoniazid, para-aminosalicylic acid (PAS), streptomycin, and viomycin.

In 11 patients chest fluid was cultured and from five of these *Mycobacterium tuberculosis* was cultured. The presence of recoverable tubercle bacilli from the chest fluid did not significantly influence the outcome of the disease.

There is little doubt today that the treatment of pneumothorax in association with tuberculosis calls for immediate and prompt negative pressure catheter drainage of the pleural cavity. Five of the 11 patients in whom catheter drainage was not used succumbed in the early period.

TISSUE COLLAPSE PRESENTS THREAT

In some patients the collapse of functioning pulmonary tissue represents the immediate threat to life.

Prolongation of ineffectual treatment of empyema, tuberculous or not, results in a chronic empyema with a thickened ring, contracted interspaces, and a rigid chest wall. In such instances, decortication, even if the underlying lung permits, does not always result in good function. The additional hazard of multiple operative procedures is also present. Thus the price of delaying catheter drainage and rapid re-expansion of the lung may be a total thoracoplasty with or without pleuropneumonectomy.

Recovery of a tuberculous patient with a spontaneous pneumothorax without specific treatment for the pneumothorax is possible but is not to be relied upon. In the 17 patients in this series treated with prompt and vigorous catheter drainage there were no immediate deaths and only one late death. There were seven deaths in 11 patients who did not have catheter treatment, five deaths being immediate and two late.

Small tubes or catheters cannot be relied upon for the treatment of pneumothorax secondary to tuberculosis.

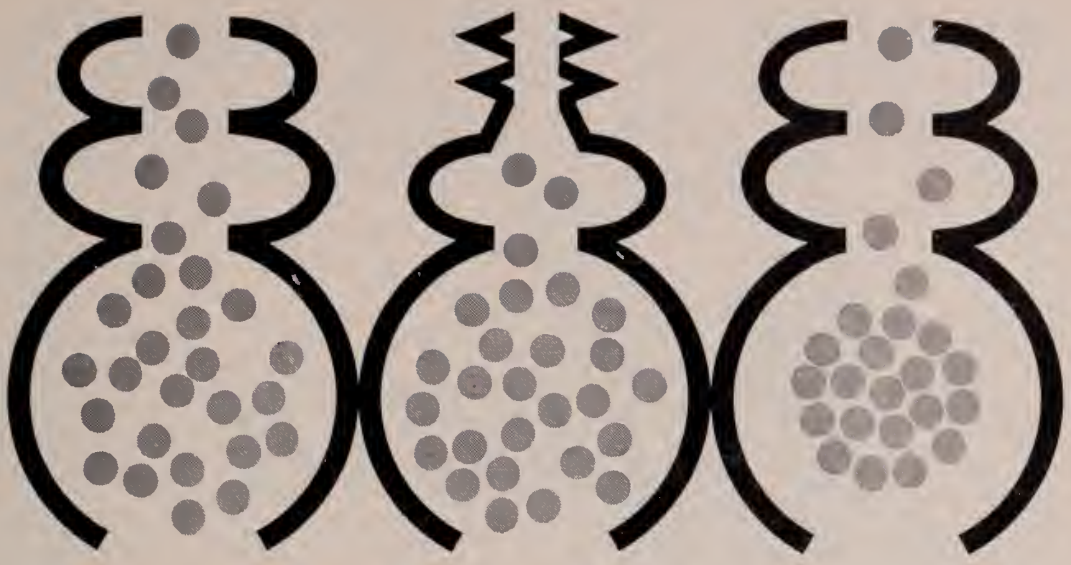
In four patients, immediate catheter drainage and suction was not successful. In two patients the collapsed lung failed to expand. These two patients developed subcutaneous emphysema. It was obvious that the catheters inserted were either not large enough, or not properly placed to evacuate the continuing air leak which forced its way interstitially. One of these patients finally underwent a successful thoracoplasty with obliteration of the air-containing space and the second patient was successfully treated with a right upper lobectomy, decortication, and four rib thoracoplasty. Although these patients ultimately did well, more expert use of catheter suction would have simplified their care. In the other two patients in whom catheter drainage and suction were considered to be unsuccessful, the lung re-expanded, but it was not possible to maintain the re-expansion after varying periods of success. The bronchopleural fistulas remained open and empyema ultimately developed.

The experience with one patient directed our attention to the possibility that pneumothorax resulting from the rupture of a tuberculous lesion might best be treated in certain instances by immediate pulmonary resection before the patient's general health deteriorated. However, the total experience with this group of patients suggests that early resection will rarely be required. In another case, the patient's general condition improved markedly during the period of catheter drainage and antituberculosis drugs.

It is probably only in a rare occasion that immediate pulmonary resection for spontaneous pneumothorax with complicating tuberculosis might be considered necessary.

New Jersey Tuberculosis and Health Association

15 East Kinney Street, Newark 2, New Jersey



lowers motility | relieves cramping | stops diarrhea

LOMOTIL® Antidiarrheal tablets and liquid

(brand of diphenoxylate hydrochloride with atropine sulfate)

Traditionally the most effective means of slowing excess intestinal motility in diarrhea and so of relieving the disorder have been the opium derivatives. Now Lomotil makes available an antidiarrheal agent[1] of greater therapeutic efficiency than morphine.

By controlling hypermotility, the basic mechanical dysfunction of diarrhea, Lomotil reduces the frequency and fluidity of stools, diminishes cramping and controls diarrhea in many patients in whom other drugs have proved inadequate.

In a recent clinical report Cayer and Sohmer[2] state: "The alleviation of symptoms [with Lomotil] was usually prompt, occurring within 24 to 72 hours even in the long-standing chronic cases. . . . A surprisingly satisfactory response was obtained in 75 per cent of the patients with regional enteritis and in 63 per cent of those with ulcerative colitis, all of whom had failed to respond to other measures."

The high therapeutic efficiency of Lomotil, its safety, convenience and economy may be used to advantage in acute or chronic diarrhea.

Dosage: For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily. Maintenance dosage may be as low as two tablets daily.

Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. Recommended dosage schedules should not be exceeded.

Note: Lomotil is an exempt preparation under Federal narcotic statutes.

Detailed information and directions for use in children and adults are available in Physicians' Product Brochure No. 81. G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

1. Janssen, P. A. J., and Jageneau, A. H.: A New Series of Potent Analgesics: Dextro 2:2-Diphenyl-3-Methyl-4-Morpholino-Butyrylpyrrolidine and Related Amides. I. Chemical Structure and Pharmacological Activity, J. Pharm. Pharmacol. 9:381-400 (June) 1957.
2. Cayer, D., and Sohmer, M. F.: Long-Term Clinical Studies with a New Constipating Drug, Diphenoxylate Hydrochloride, N. Carolina Med. J. 22:600-604 (Dec.) 1961.

G. D. SEARLE & CO. *Research in the Service of Medicine*

SYNergized
aspIRIN

Synirin®

ANALGESIA

WITH A DOSAGE AS FLEXIBLE AS ASPIRIN

The simultaneous action of aspirin and pentobarbital begins promptly and lasts four to five hours. Each tablet contains aspirin 5 grs. and pentobarbital (acid) 1/8 gr. Synirin was formulated for a two-tablet dose for adults and a one-tablet dose for children from 5 to 12 years of age. It may be repeated every four hours for the relief of pain.

Dispensed in bottles of 100 and 1000 tablets

WM. P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

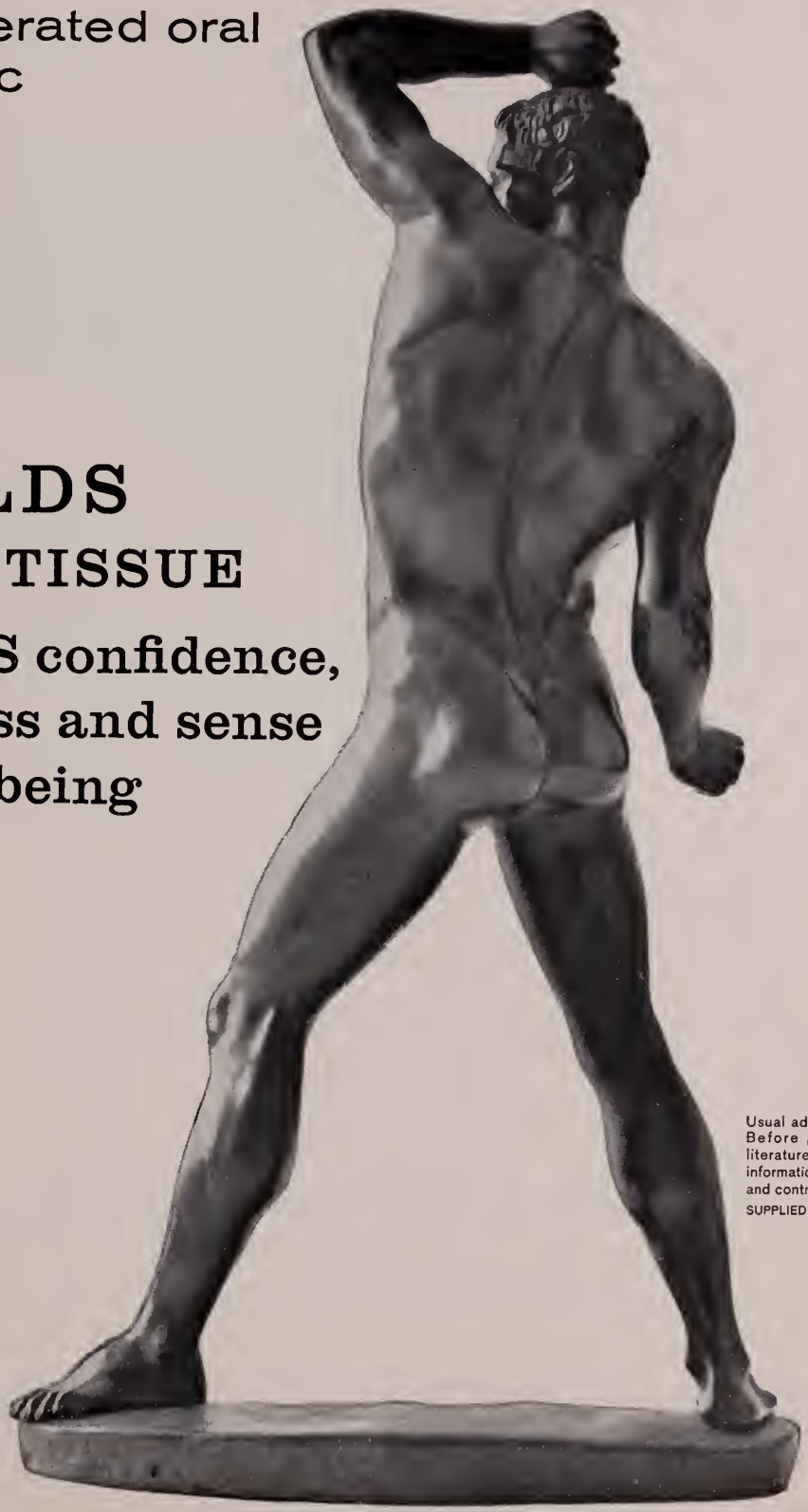
Manufacturers of ethical pharmaceuticals since 1856

THE SIGNIFICANT NEW PHYSIOTONIC

WINSTROL®

BRAND OF STANOZOLOL

well tolerated oral anabolic



BUILDS
BODY TISSUE

BUILDS confidence, alertness and sense of well-being

Usual adult dose: 1 tablet t.i.d. Before prescribing, consult literature for additional dosage information, possible side effects and contraindications.

SUPPLIED: 2 mg. tablets. Bottles of 100.

Winthrop
LABORATORIES
New York 18, N.Y.

With WINSTROL, patients look better...feel stronger—because they are stronger

Webcor Music Man

STEREOPHONIC HIGH FIDELITY TAPE RECORDER

...the ultimate in tape recorder performance!



PRICED AT only $198.80

- 2 and 4 track stereo operation
- 3 speeds—1⅞, 3¾, and 7½ ips.
- New, simplified "push-lever" operation
- Self-contained stereo record and playback
- Digital tape counter with pushbutton reset
- Dual volume controls—one for each channel
- Dual bass and treble controls

If you're the "one in a hundred" with a highly critical ear for perfection in sound, you'll be satisfied with nothing less than the new Webcor "MUSIC MAN" stereo tape recorder. And it's ever so simple to operate! Just push the lever up to "Play"... push it down to "Stop"... move it to the left to "Rewind"... to the right for "Fast Forward." Treat yourself to a thrilling new hearing experience. Ask for a demonstration today at—

Write for catalog to Exclusive N. J. Wholesale Distributors

ALL-STATE DISTRIBUTORS

INCORPORATED

457 CHANCELLOR AVE. NEWARK, N. J.

WAverly 3-4900



is what makes this party trick work

BALANCE makes Caroid & Bile Salts Tablets an effective, gentle laxative just as BALANCE keeps this glass of water tilted on the side of a coin.

The balanced combination of five agents in Caroid & Bile Salts Tablets improves normal digestion of proteins...increases flow of bile from the liver...gently stimulates peristalsis and encourages a regular and normal elimination pattern.

Each Caroid & Bile Salts Tablet contains Caroid (brand of digestive ferment from Carica Papaya) 1¼ gr.; capsicum 1/10 gr.; phenolphthalein ½ gr.; bile salts as in 1⅛ gr. desiccated whole bile; and extract of cascara sagrada ¾ gr.

CAROID® & BILE SALTS TABLETS

BREON American Ferment Division,
BREON LABORATORIES INC., New York 18, N. Y., Subsidiary of Sterling Drug Inc.

Secret of the party trick: On the obverse of a half dollar, find the exact spot between the goddess's gown and her right foot. Balance the glass (half filled with water) in this groove.

DUGAN'S

"Bakers for the Home"

New - LITE DIET BREAD

(White Bread Baked Without Shortening)

Calories per Slice 42 Calories per oz. 70

ALSO

SALT-FREE BREAD
GLUTEN AND PROTEIN BREADS
100% WHOLE WHEAT
100% Whole Wheat Crackers

New York New Jersey
Connecticut Pennsylvania

"At Your Door or To Your Store
It's DUGAN'S for BETTER Baked Goods"

Phone for Delivery

HUmboldt 2-6007 in Newark
(or your local phone book for branch nearest you)

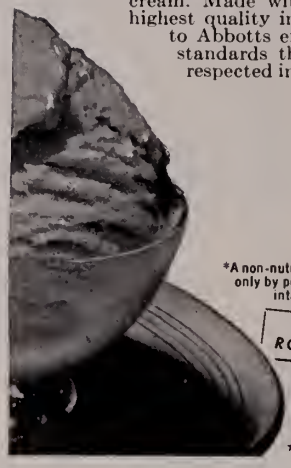
NOW! **DIABETICS CAN ENJOY**
(UNDER MEDICAL ADVICE)

Abbotts

ARTIFICIALLY SWEETENED

ICE CREAM

Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards — standards that are most highly respected in the dairy industry



*A non-nutritive artificial sweetener for use only by persons who must restrict their intake of ordinary sweets.

IN HANDY ROUND PINTS

At Abbotts and Jane Logan Dealers
Abbotts Dairies

"Prescribe with Confidence"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR
FOR MEN - WOMEN - CHILDREN



SOLD ON Rx ONLY
OUTFLAIR SHOES
FOR CLUB FEET

177A JEFFERSON AVE. **69 WESTWOOD AVE.** **350 MAIN ST.**
PASSAIC, N. J. **WESTWOOD, N. J.** **HACKENSACK, N. J.**

Dennis Brown Splints — in all sizes — carried in stock

RELIEVE THE COLD SUPPRESS THE COUGH WITH NEW

'EMPRAZIL-C'

TABLETS

ANTITUSSIVE ▪ DECONGESTANT ▪ ANALGESIC

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Acetophenetidin	150 mg.
Aspirin (Acetylsalicylic Acid)	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming.

Complete literature available on request.

Also available without codeine as

'EMPRAZIL'®

TABLETS



BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.

KESSLER INSTITUTE FOR REHABILITATION

- A voluntary, non-profit, non-sectarian, specialty hospital and rehabilitation center for physically handicapped children and adults providing intensive and comprehensive medical, social, psychological, and vocational services for patients with any physical impairment due to a congenital condition, accident or disease.
- In-patient and out-patient service facilities include a new 48-bed, air-conditioned in-patient wing, swimming pool, and modern treatment facilities.
- Fully accredited by the Joint Commission of Accreditation of Hospitals.

ADMISSION BY MEDICAL REFERRAL TO DIRECTOR OF ADMISSIONS

HENRY H. KESSLER, M.D., Medical Director
WILLIAM K. PAGE, Executive Director
Telephone: RE 1-3600

NEW YORK FERTILITY INSTITUTE

For the Investigation of Problems of Human Infertility

The Institute provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

Patients are accepted by the Institute only by doctor referral and returned to the referring physician after appropriate studies have been made, together with a complete detailed report of the findings of the Institute and its consultants and recommendations for therapy. Literature on request.

123 East 89th Street, N. Y. 28, N. Y.
Phone: TR 6-9300

NUTRITION CONTROL CERTIFIED

A NATURAL Treatment For Gastro-Intestinal Disorders

An implantation of l. acidophilus bacilli in the digestive tract will frequently restore intestinal flora to a normal, healthy condition. Walker-Gordon Acidophilus (a 2% butterfat product made from Walker-Gordon Certified Milk) abounds in lactobacilli acidophilus . . . 500 million per ml. Write or phone for professional sample of Acidophilus and complete information.

Guaranteed Free of Penicillin

WALKER-GORDON ACIDOPHILUS

Walker-Gordon Certified Milk Farm, Plainsboro, N.J. SWinburne 9-1234
New York: WAlker 5-7300 ☆ **Phila.: PEnnypacker 5-3465**
Also Producers of Certified Raw, Pasteurized, Homogenized-Vit. D, Skimmed and Fresh Lo-Sodium Milks.
Available through leading Milk Dealers or write Walker-Gordon



Robitussin®

glyceryl guaiacolate

For the special care that winter coughs demand, both Robitussin formulas contain glyceryl guaiacolate which enhances the flow of Respiratory Tract Fluid (RTF) almost 200%.

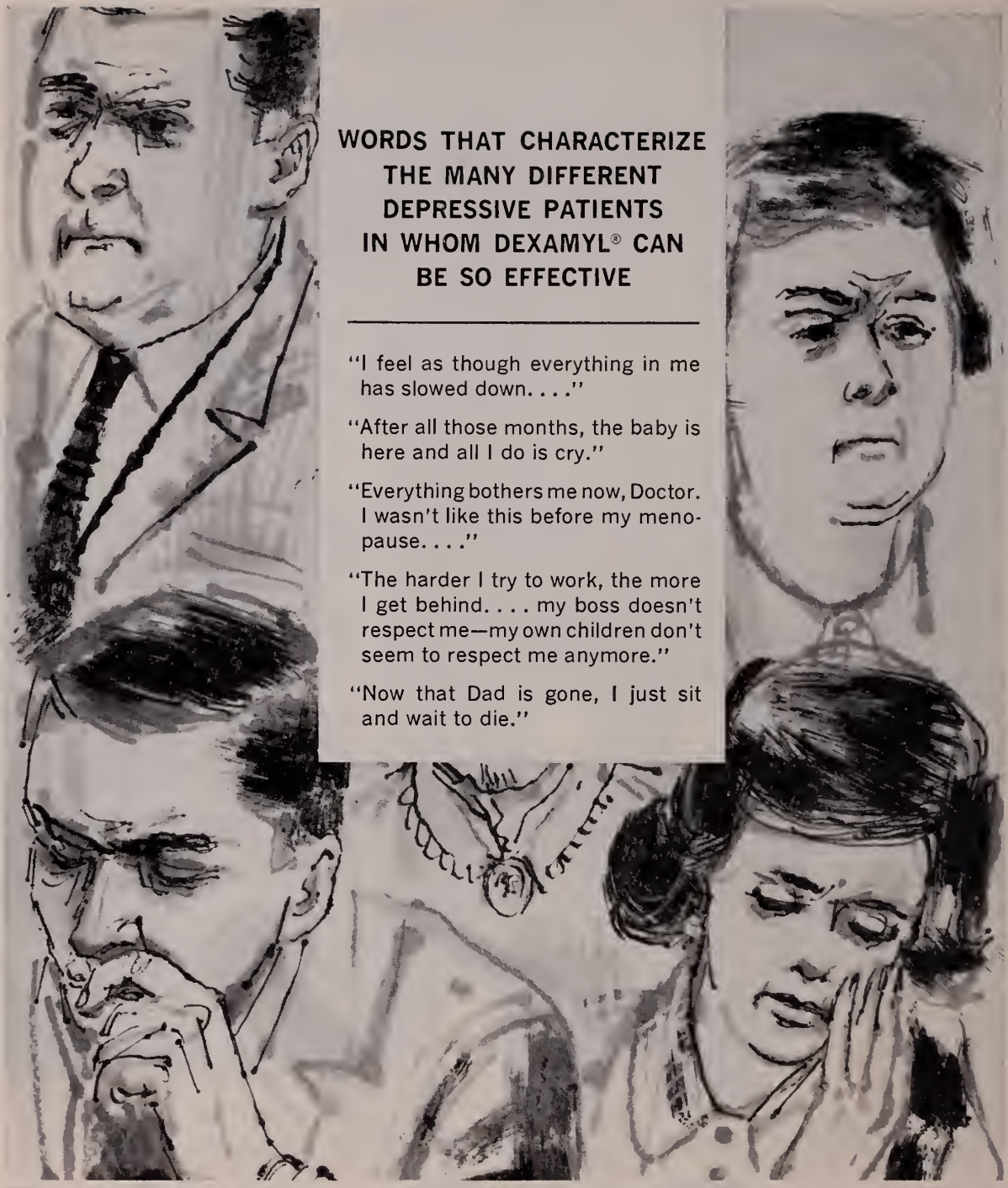
Of practically all drugs now used clinically as expectorants, glyceryl guaiacolate exerts the most intense and prolonged action.

Increased RTF promotes bronchial drainage by liquefying tenacious sputum and exerts a soothing, demulcent effect on irritated bronchial mucosa that helps reduce the frequency of dry, tickling, unproductive coughs.

Robitussin A-C also contains pheniramine maleate to control associated allergic manifestations and codeine phosphate to suppress persistent, unproductive coughs.

Formulas—Robitussin: Glyceryl guaiacolate 100 mg. per 5 cc. Robitussin A-C: Glyceryl guaiacolate 100 mg., Pheniramine maleate 7.5 mg., Codeine phosphate 10 mg. per 5 cc.

A. H. Robins Co., Inc., Richmond 20, Virginia



WORDS THAT CHARACTERIZE THE MANY DIFFERENT DEPRESSIVE PATIENTS IN WHOM DEXAMYL® CAN BE SO EFFECTIVE

"I feel as though everything in me has slowed down. . . ."

"After all those months, the baby is here and all I do is cry."

"Everything bothers me now, Doctor. I wasn't like this before my menopause. . . ."

"The harder I try to work, the more I get behind. . . . my boss doesn't respect me—my own children don't seem to respect me anymore."

"Now that Dad is gone, I just sit and wait to die."

DEXAMYL® SPANSULE® brand of sustained release capsules

FORMULA: Each 'Spansule' capsule No. 1 contains 10 mg. of Dexedrine® (brand of dextro amphetamine sulfate), and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Spansule' capsule No. 2 contains 15 mg. of 'Dexedrine' (brand of dextro amphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming]. The active ingredients of the 'Spansule' capsule are so prepared that a therapeutic dose is released promptly and the remaining medication, released gradually and without interruption, sustains the effect for 10 to 12 hours.

INDICATIONS: (1) For mood elevation in depressive states; (2) for control of appetite in overweight.

USUAL DOSAGE: One 'Dexamyl' *Spansule* capsule taken in the morning for 10- to 12-hour effect.

SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

CAUTIONS: Use with caution in patients hypersensitive to sympathomimetic compounds or barbiturates and in coronary or cardiovascular disease or severe hypertension.

SUPPLIED: 'Spansule' capsules No. 1 (1 dot on capsule) and No. 2 (2 dots on capsule), in bottles of 30.

Prescribing information October 1962.

Smith Kline & French Laboratories

REPRESENTATIVE FUNERAL DIRECTORS

OF THE STATE OF NEW JERSEY

Special and Dependable Service Day and Night. Special Attention Given to Hospital Calls, Train and Express Shipments.

Place	Name and Address	Telephone
ADELPHIA	C. H. T. Clayton & Son	FReehold 8-0583
BELMAR	J. Henry Dangler Funeral Home, 304 - 8th Ave.	MUtual 1-3900
BLOOMFIELD	George Van Tassel's Community Funeral Home	PIlgrim 3-1234
BOONTON	Lewis & Carey Incorporated, 312 W. Main St.	DEerfield 4-0842
CHATHAM	Wm. A. Bradley Funeral Home, 345 Main St.	MErcury 5-2428
CRANBURY	A. S. Cole Son & Co., Main St.	EXport 5-0770
ELIZABETH	Aug. F. Schmidt & Son, 139 Westfield Ave.	ELizabeth 2-2268
ENGLEWOOD	Greenleaf Funeral Home, Inc., 108 W. Palisade Ave.	LOwell 8-0416
FREEHOLD	Higgins Memorial Home, 20 Center St.	HOpkins 2-0895
JERSEY CITY	McLaughlin Funeral Home, 591 Jersey Ave.	OLdfield 3-2266
LINDEN	Don McCracken Funeral Home, 2124 St. Georges Ave., E.	ELizabeth 2-9190
METUCHEN	Runyon Mortuary, 568 Middlesex Ave.	LIberty 8-0149
NEWARK	Barrish Funeral Home, 684 Clinton Ave.	ESsex 3-1551—9179
PATERSON	Legg, R. Charles D. & Sons, 384 Broadway	SHerwood 2-2385
RAMSEY	The Harold Van Emburgh Funeral Home, Inc.	DAvis 7-0030
RIDGEWOOD	C. C. Van Emburgh, Inc., 306 E. Ridgewood Ave.	GIlbert 5-0344
RIVERDALE	George E. Richards, Newark Turnpike	TEmple 5-0164
SOUTH RIVER	Rezem Funeral Home, 190 Main St.	SOuth River 6-1191
TRENTON	Ivins & Taylor, Inc., 77 Prospect St.	EXport 4-5186

LONG TERM AUTO LEASING

. . . A SERVICE ESPECIALLY PLANNED FOR DOCTORS!

M.D. PLATES FREE, TOO!

AAL LONG TERM SINGLE CAR AND FLEET RENTALS

Call ORange 6-7137 or MAIL COUPON TODAY

Lease a brand new Cadillac or other fine car from American and you'll never **buy** again. Save money, time and trouble. One modest monthly payment takes care of everything . . . insurance, maintenance, repairs, depreciation . . . and the payments are 100% tax deductible! Borrow a car—free of charge—in case of accident or breakdown.

INCLUDES

- Registration and plates
- Full maintenance
- Insurance

Liability $250/$500,000
Property damage $20,000
Deductible collision,
fire and theft

AMERICAN AUTO LEASING COMPANY
120 Halsted St., East Orange, N. J.
Please send me the AAL Long Term Leasing Plan.

Wide Selection of '63 Models

Special requirements _____

_____

Name _____

Address _____

City _____ State _____

ALL YOU BUY IS GAS AND OIL

ASK FOR BROCHURE

AAL **AMERICAN AUTO LEASING COMPANY**

120 Halsted Street, East Orange, New Jersey • ORange 6-7137

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

Place	Name and Address	Telephone
BERGENFIELD	Horn's Pharmacy, 475 So. Washington Ave.	DUmont 4-1119
BLACKWOOD	Worrell's Pharmacy, 12 So. Black Horse Pike	CAnal 7-0430
BLOOMFIELD	Burgess Chemist, 56 Broad St.	PIlgrim 3-1005
BLOOMFIELD	Jay W. Clark, Pharmacist, 170 Broad St., Belleville Ave.	PIlgrim 3-4150
CLOSTER	Mid Town Pharmacy, 237 Closter Dock Road	PO. 8-0070
DUMONT	Lenrow's Pharmacy, Inc., 10 W. Madison Ave.	DUmont 4-0842-1500
EDISON TOWNSHIP	Walter's Pharmacy, 1034 Amboy Ave.	LIberty 8-2614
EMERSON	Emerson Pharmacy, 201 Kinderkamack Road	COlfax 2-4999
FARMINGDALE	Burke Rexall Drugs, Main St. opp. Bank & Post Office	WEbster 8-9051
FORDS	Fords Pharmacy, Inc., 550 New Brunswick Ave.	HIllcrest 2-4568
FREEHOLD	Wood's Pharmacy, 2 E. Main St., cor. South	FReehold 8-0668
HIGHLANDS	Highlands Pharmacy, 148 Bay Ave.	872-1550
JERSEY CITY	J. B. Feinberg Pharmacy, 659 Newark Ave.	OLdfield 3-6376
JERSEY CITY	Fred T. Fiore, 14 Rose Ave.	DElaware 3-7509
JERSEY CITY	Honiberg Drug & Surgical Supply Co., 618 Newark Ave.	SWarthmore 8-6700
JERSEY CITY	Lauria's Pharmacy, 768 West Side Ave.	HEnderson 3-1519
KEYPORT	Sav-On-Drugs, J. Meisler, opp. Post Office.	COlfax 4-0904
LAKEWOOD	Burke Rexall Drugs, Cor. 4th and Monmouth	FOxcroft 3-7133
MILLTOWN	Milltown Pharmacy, 21 No. Main St.	MIlltown 8-0081
MILLVILLE	Richard H. Knowles Pharmacy, 600 No. High St.	TAylor 5-0721
MORRISVILLE, PA.	Pryor's Pharmacy, Bridge St. & Penna Ave.	Cypress 5-7416
MOUNT HOLLY	Goldy's Pharmacy, Main & Washington Sts.	AMherst 7-3800
MOUNT HOLLY	Mount Holly Pharmacy, 64 Main St.	AMherst 7-0453
NEWARK	Giannotto's Pharmacy, 195 First Ave.	HUmboldt 2-8220
NEWARK	Marquier's Pharmacy, Sanford and So. Orange Aves.	ESsex 3-7721
NEWARK	7th Avenue Pharmacy, Inc., 71 - 7th Ave.	HUmboldt 3-7676
NEW BRUNSWICK	Bode Pharmacy, 120 French St.	KIlmer 5-2676
NEW BRUNSWICK	Tobin's Drug Store, 335 George St.	CHarter 9-0780
NEW BRUNSWICK	Zajac's Pharmacy, 225 George St.	KIlmer 5-0582
OCEAN CITY	Selvagn's Pharmacy, 862 Asbury Ave.	OCean City 3535
ORANGE	Highland Pharmacy, 536 Freeman St.	ORange 3-1040
PASSAIC	Wollman Pharmacy, 143 Prospect St.	PRescott 9-0081
PATERSON	Vallario's Pharmacy, 357 Totowa Ave.	ARmory 4-2139
PAULSBORO	Nastase's Pharmacy, 762 Delaware St.	PAulsboro 8-1569
PENNSAUKEN	Thor's Rexall Drugs, 4919 Westfield Ave.	NOrmandy 2-0848
PRINCETON	The Thorne Pharmacy, 168 Nassau St.	WAlnut 4-0077
RAHWAY	Bell Drug Store of Rahway, Inc., 1552 Irving St.	FUlton 1-2000
RAHWAY	Kirstein's Pharmacy, 74 East Cherry St.	FUlton 8-0235

(Continued on following page)

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

(Continued from preceding page)

RIDGEFIELD PARK	Lloyd's Prescriptions, 209 Main St.	Diamond 2-8383
RUMSON	Rumson Pharmacy, W. E. Fogelson	842-1234
SOUTH AMBOY	Madura Pharmacy, 115 N. Broadway	PArkway 1-1732
SOUTH AMBOY	Peterson Pharmacy, 132 No. Broadway	PArkway 1-0137
SOUTH ORANGE	Taft's Pharmacy, 2 South Orange Ave.	SOuth Orange 2-0063
TRENTON	Adam & Sickles, State & Prospect Sts.	OWen 5-6396
TRENTON	Episcopo's Pharmacy, Chambers & Liberty Sts.	EXport 3-3017
TRENTON	Foy's Drug Store, 3024 So. Broad St.	EXport 3-2367
UNION	Colonial Rexall Pharmacy, 1448 Morris Ave.	MUrdock 7-3100
UNION	Perkins Union Center Pharmacy	MUrdock 6-0877
WEST NEW YORK	Gemignani Pharmacy, 6129 Park Ave.	UNion 5-1296
WEST NEW YORK	The Owl Pharmacy, 6611 Bergenline Ave.	UNion 5-0384
WEST ORANGE	West Orange Pharmacy, 443 Main St.	ORange 4-9824
WRIGHTSTOWN	Bowen's Pharmacy, 152 Fort Dix Road	RAymond 3-2176

FAIR OAKS HOSPITAL

SUMMIT, NEW JERSEY

CRestview 7-0143

OSCAR ROZETT, M.D.
Medical Director

MOLLIE KENNEDY, R.N.
Director, Nursing Service

EDWARD R. DUTY, M.D.
Clinical Director

N. M. JANI, M.D.
S. D. ESTRADA, M.D.
Associate Psychiatrists

THOMAS P. PROUT, JR.,
Administrator

AN 85 BED INTENSIVE TREATMENT PSYCHIATRIC UNIT

Certified by
The Joint Commission on Accreditation of Hospitals
The Central Inspection Board, American Psychiatric Assn.







CLASSIFIED ADVERTISEMENTS

WANTED FOR SALE TO LET
SITUATIONS, ETC.

Send replies to box number c/o The Journal
P. O. Box 904, Trenton 5, N. J.

$3. for 25 words or less; additional words 5c each
Forms close 15th of the preceding Month.

BOARD CERTIFIED PATHOLOGIST—Age 52, with broad hospital and research background, seeks change of position. Write Box 46, c/o THE JOURNAL.

ASSOCIATE WANTED IMMEDIATELY—By Board Certified allergist. Active allergy practice in the New York-New Jersey area. Salary or percentage. Write Box No. 47, c/o THE JOURNAL.

YOUNG WELL-TRAINED PHYSICIAN—To join a busy practice in suburban New Jersey. Beautiful new building under construction. No investment required. Up to $12,000 for the right man. Early partnership anticipated. Mostly medical and pediatrics. Some obstetrics and ample surgery available. Write now to D. F. GEARING ASSOCIATES, Business Consultants to the Medical Profession, 11 Court Street, White Plains, New York.

ASSISTANT TO MEDICAL DIRECTOR—For 300 bed county accredited hospital; training or experience in chest diseases and internal medicine (geriatrics) is desirable. Must have New Jersey license. Modern furnished apartment (for single or married persons) and full maintenance at nominal cost; free hospitalization, paid vacation, sick leave and holidays; annual increments. Starting salary, $14,800. Contact Eugene Nargiello, M.D., Superintendent and Medical Director, John E. Runnells Hospital for Chest Diseases, Berkeley Heights, New Jersey.

STAFF PHYSICIANS—For 300 bed County accredited hospital. Training or experience in chest diseases and internal medicine (geriatrics) is desirable but not a requirement. Must have a New Jersey license. Modern furnished accommodations (for single persons) and full maintenance at nominal cost; free hospitalization, paid vacation, sick leave, and holidays; annual increments. Salary open. Contact: Eugene Nargiello, M.D., Superintendent and Medical Director, John E. Runnells Hospital for Chest Diseases, Berkeley Heights, New Jersey.

UPPER MONTCLAIR OFFICE TO SHARE—Air-conditioned. Recently occupied by Internist. 500 ma. X-ray, EKG and lab. available. Call PI 4-3636.

FOR RENT—MONTCLAIR, New Jersey. Office in Medical Building. Furnished. Full occupancy, except Thursday. Available January 1, 1963. $85.00 monthly. Write Box No. 48, c/o THE JOURNAL.

GENERAL PRACTITIONER WANTED—South Bound Brook, New Jersey, population 4,000. Only physician in town. Present physician leaving to specialize. Office for rent. Write Box 36, c/o THE JOURNAL.

INTERNIST - CARDIOLOGIST — Wanted immediately to take over deceased doctor's busy practice. Five-room equipped office for lease. Hospital nearby. Contact Mrs. F. A. Kessler, 87 Green Street, Woodbridge, New Jersey, ME 4-0887.

FOR SALE—Paterson, New Jersey. Corner house, ten rooms. Advantageously located. Ideally suited for doctor's office and living quarters. Immediate occupancy. Call 667-0843. Write: O. Edelman, 26 Stockton Place, Nutley, New Jersey.

HOME-OFFICE FOR SALE — Irvington. Physician retiring. Nine room house—excellent location. Fully-equipped office including X-ray. Immaculate condition. Solo or group. Call ESsex 3-9117.

MEDICAL PRACTICE FOR SALE—Excellent, long established, due to sudden death. Wonderfully equipped modern offices: X-ray, etc. Beautiful house and garden. Prime location in city in the heart of South Jersey. Rich farm area. Growing population 50,000. Write Box 39, c/o THE JOURNAL.

FOR RENT—2 suites of offices for medical profession, unequipped. Area needs general practitioner and specialist. Fine residential area on well-traveled routes 202-206. Somerville 1 mile. Contact B. Lewin 722-6666.

STUYVESANT PROFESSIONAL BUILDING—600 sq. ft. suite. Present occupants are: Dentist, Allergist, Speech Clinic, Optometrist. Excellent auto and bus connections. 1146 Stuyvesant Avenue, Irvington, New Jersey. ES 3-1073.

PRACTICE AND HOME FOR SALE—Busy young general practitioner retiring to go into full-time research, wishes to sell his $30,000 practice and his beautiful combination home-office in rapidly growing area in central New Jersey. This is an ideal opportunity for a physician who wants to be busy right away with a beautiful home-office and complete equipment. Write for complete details to: D. F. GEARING ASSOCIATES, Business Consultants to the Medical Profession, 11 Court Street, White Plains, New York.

CLASSIFIED ADVERTISEMENTS

FOR SALE—Residence, apartment, and adjoining professional offices in a central New Jersey community with tremendous growth potential. Established doctor's location, highly desirable for specialized practice. For complete details consult Claudia Pascale, Realtor, 68 North Bridge Street, Somerville. RA 2-1032.

RENT OR SALE—Active general practice in New Jersey shore area. Can introduce. Leaving to specialize. Equipped office and residence. Negotiable terms. Write Box 50, c/o THE JOURNAL.

IDEAL LOCATION—for medical practice, centrally located in built-up community on state highway, for sale or long lease. TW 9-3269.

RADIOLOGICAL PRACTICE FOR SALE—Paterson, New Jersey, for the cost of office building, diagnostic and therapy equipment, lead-lined rooms; 2 tenants' rentals more than enough to cover taxes and other expenses. Reasonable terms. Write Box No. 49, c/o THE JOURNAL.

THE LITERARY FORGE—Port Republic, New Jersey. Save time and energy—send us the rough draft of your medical article or book for finishing. Careful editing and typing. Rewriting for brevity, clarity, and readability. Write for details.

CAN YOU GUARANTEE THAT YOU WON'T BE INVOLVED IN AN ACCIDENT TONIGHT?

Of course not.

But WE GUARANTEE that if you are ever disabled through accident or sickness, we'll PAY YOU EACH MONTH. Wise physicians and dentists are protecting themselves against "Loss of Time" with us.

For full details, without obligation, send the coupon below — TODAY!

PHYSICIANS MUTUAL INSURANCE COMPANY

formerly

Physicians Casualty and Health Associations

"The Doctors Company"

Insuring Physicians & Dentists for 60 years.

Physicians Mutual Insurance Company
115 So. 42nd Street
Omaha 31, Nebraska

Please send me details on your insurance protection plans.

NAME_____ AGE_____

ADDRESS_____

CITY_____ STATE_____

The Morristown Rehabilitation Center

66 MORRIS STREET **MORRISTOWN, NEW JERSEY**

JEFFERSON 9-3000



NATHAN KAPLAN, M.D., Physiatrist
MARY E. JOHNSON, Chief Therapist

ANN G. McMANUS, R.N.
Director of Nursing Service

AUDREY E. TAHLMORE
Administrator

A 38-bed rehabilitation unit specializing in orthopedic and neurological disabilities. Speech therapy, Occupational therapy and psychological evaluation available.

- - - - -

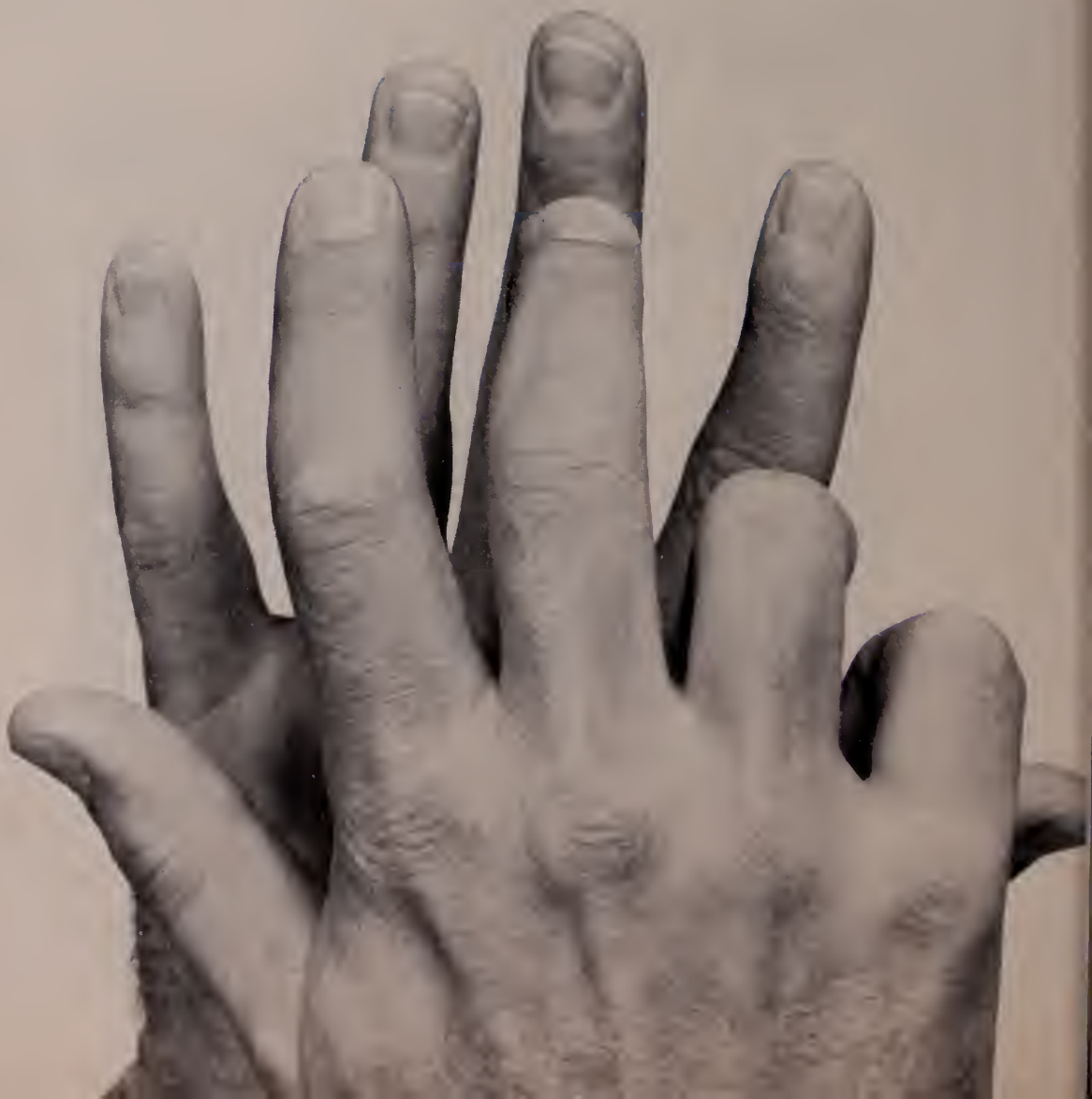
AMERICAN HOSPITAL ASSOCIATION ACCREDITATION
MEMBER NEW JERSEY LICENSED NURSING HOME ASSOCIATION

in severe respiratory infections
refractory to other measures.

CHLOROMYCETIN®

(chloramphenicol, Parke-Davis)

for established clinical efficacy against susceptible organisms[1-]



In Friedlander's Pneumonia[3,13]

Although the prognosis in Friedlander's pneumonia is poor, treatment with CHLOROMYCETIN has shown a good response when susceptible strains of *Klebsiella pneumoniae* are incriminated.

In *Hemophilus Influenzae* Pneumonia[3,4,13,14]

Because the invading organism is usually sensitive to CHLOROMYCETIN, this agent is generally effective in pneumonias caused by *H. influenzae*.

In Staphylococcal Pneumonia[1-8,13]

CHLOROMYCETIN continues to remain effective against many resistant strains of staphylococci, and—alone or in combination with other antibiotics—should be considered when other antistaphylococcal drugs are ineffective.

In Acute Epiglottitis[4,10,11]

This condition is most often caused by *H. influenzae*, most strains of which are sensitive to CHLOROMYCETIN. Therapy should be instituted at once, since the disease may progress from the first symptoms to a severe respiratory obstruction in four to six hours.

In Pneumonias Due to Gram-negative Bacilli[9]

Because of its broad-spectrum activity, CHLOROMYCETIN is often effective in pneumonias caused by sensitive strains of *Aerobacter, Proteus* of various species, *Paracolobactrum,* and other gram-negative pathogens encountered with increasing frequency in serious respiratory tract infections.

In Staphylococcal Empyema[12]

The infiltrating lesions of staphylococcal empyema are often difficult to eradicate. While CHLOROMYCETIN should only be used when the infection has been resistant to treatment with other antistaphylococcal drugs, therapy with CHLOROMYCETIN, in conjunction with surgical procedures, will often bring favorable results.

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100. See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections such as colds, influenza, or viral infections of the throat, or as a prophylactic agent.

Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Thacher, H. C., & Fishman, L.: *J. Maine M. A.* **52**:84, 1961. (2) Hopkins, E. W.: *Postgrad. Med.* **29**:451, 1961. (3) Hall, W. H.: *M. Clin. North America* **43**:191, 1959. (4) Krugman, S.: *Pediat. Clin. North America* **8**:1199, 1961. (5) Ede, S.; Davis, G. M., & Holmes, F. H.: *J.A.M.A.* **170**:638, 1959. (6) Wolfsohn, A. W.: *Connecticut Med.* **22**:769, 1958. (7) Calvy, G. L.: *New England J. Med.* **259**:532, 1958. (8) Hendren, W. H., III, & Haggerty, R. J.: *J.A.M.A.* **168**:6, 1958. (9) Cutts, M.: *Rhode Island M. J.* **43**:388, 1960. (10) Berman, W. E., & Holtzman, A. E.: *California Med.* **92**:339, 1960. (11) Vetto, R. R.: *J.A.M.A.* **173**:990, 1960. (12) Sia, C. C. J., & Brainard, S. C.: *Hawaii M. J.* **17**:339, 1958. (13) Rosenthal, I. M.: *GP* **17**:77 (March) 1958. (14) Gaisford, W.: *Brit. M. J.* **1**:230, 1959.

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan

03863

specific for anxiety & tension

Librium

The singular specificity of Librium in controlling anxiety and tension has proven to be an advantage in a wide range of disorders characterized by anxiety of varying degrees. Notably effective in patients whose symptoms are primarily emotional, Librium is equally valuable when organic disease is aggravated or prolonged by accompanying anxiety. Coupled with its effectiveness is an outstanding record of safety. Librium has few, if any, of the unwanted side effects associated with tranquilizers and daytime sedatives—no extrapyramidal effects, no autonomic blocking, and no dulling of mental alertness. Consult literature and dosage information, available on request, before prescribing.

the successor to the tranquilizers

LIBRIUM® Hydrochloride—7-chloro-2-methylamino-5-phenyl-3H-1,4-benzodiazepine 4-oxide hydrochloride



ROCHE

ANNUAL MEETING — MAY 11 - 15, 1963 — HADDON HALL, ATLANTIC CITY

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Entered as second-class matter September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879
Second Class Postage Paid at Orange, N. J.

VOL. 60, NO. 2 FEBRUARY, 1963 Subscriptions, $3.00 per year
Single Copies, 30 Cents.

APR 26 1963
LIBRARY

CONTENTS—Pages 51 to 98

EDITORIALS— Page

The Non-Equivalence of Equivalents 51

Pathology Dodo 52

How to Multiply Your Dollar 53

ORIGINAL ARTICLES—

Toxic Megacolon Complicating Ulcerative Colitis—Isaac Gelber, M.D. and Robert L. Lewis, M.D., Elizabeth 54

Stapes Surgery—Sidney S. Boyers, M.D., West New York 58

Reconstruction of the Esophagus—Henry J. Heimlich, M.D., New Rochelle, New York 65

Psychiatric and Alcoholic Patients in a General Hospital—Evelyn P. Ivey, M.D., Morristown 70

Eruptions and the New Drugs—Herman Beerman, M.D., Philadelphia, Pa. 73

Kartagener's Syndrome—Edwin J. Kroeker, M.D. and David P. Boyd, M.D., Boston, Mass.; Henry J. Schwarz, Jr., M.D., North Bergen 82

Our Fading Freedom—Richard I. Nevin, Trenton 86

STATE ACTIVITIES—

Universal Calibre for Syringes 57

Clothing for Handicapped Children 81

Trustees' Meeting: November 18, 1962 90

OBITUARIES 92

ANNOUNCEMENTS 93

PSYCHOSOMATIC PROFILE 94

BOOK REVIEWS 95

RESPIRATORY DISEASE ABSTRACTS 97

Roster of Officers and Committee Chairmen, Advertising Page 3A

Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

Telephone EXport 4-3154



Published Monthly Since 1904

Acceptance for mailing at special rate of postage provided for in Sec. 1103, Act of Oct. 3, 1917, authorized July 29, 1918.

Copyright 1963 by
The Medical Society of New Jersey

The Medical Society of New Jersey Endorsed Plans of

ACCIDENT AND HEALTH INSURANCE
MAJOR MEDICAL EXPENSE INSURANCE
TERM LIFE INSURANCE

****SIX POINT, HIGH LIMIT ACCIDENT INSURANCE**
(Accidental Death, Dismemberment and other Accident Benefits)

Income Protection (Accident and Sickness Insurance)

$1,200 a month new maximum Basic total disability benefit

ACCIDENT: from 1st day, up to 5 years (Partial Accident Disability, half benefit up to six months)
SICKNESS: from 8th day, up to 2 years

$600 a month new maximum Extended total disability benefit, continuing benefits beyond basic coverage.

ACCIDENT: extended to LIFE
SICKNESS: extended through SEVENTH year

Major Medical

$10,000 maximum for Covered Expenses for each accident or sickness, covering member, spouse, and eligible children. $500 deductible, 20% co-insurance.

Life

$10,000 to **$50,000** of Convertible Term Life Insurance.
(Guaranteed exchangeable at any time into Permanent Cash Value life insurance)

Applications for initial $10,000 policy and additional $10,000 policies up to $50,000 total under this plan considered during the month of November each year*.

**** SIX POINT, HIGH LIMIT ACCIDENT INSURANCE**

Up to $200,000 Six Point, High Limit Accident Insurance, covering accidental death, dismemberment, loss of sight, total and permanent disability, exposure and disappearance for member.

Up to $100,000 for spouse (without disability benefit).

Applications are subject to age limits and other company rules and regulations for acceptance of risks. New members have special privileges during the first few months of membership; ask for specific details if you were recently elected and have not received notification from us.

Information and claim service are as close as your telephone.

E. & W. BLANKSTEEN

E. & W. Blanksteen Agency, Inc.

75 MONTGOMERY STREET JERSEY CITY 2, NEW JERSEY

DElaware 3-4340

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATON, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.
EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154
(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

OFFICERS

President, Louis S. Wegryn, M.D. ..... Elizabeth
President-Elect, Jerome G. Kaufman, M.D. ..... Maplewood
First Vice-President, Charles H. Calvin, M.D. .. Perth Amboy
Second Vice-President, John J. Bedrick, M.D. ..... Bayonne
Secretary, Marcus H. Greifinger, M.D. ..... Newark
Treasurer, Daniel F. Featherston, M.D. ..... Asbury Park

Mr. Richard I. Nevin, *Executive Officer* ..... Trenton
Mrs. Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton

TRUSTEES

Samuel J. Lloyd, M.D., *Chairman* (1963) ..... Trenton
Nicholas A. Bertha, M.D., *Secretary* (1965) ..... Wharton
Louis S. Wegryn, M.D. ..... Elizabeth
Jerome G. Kaufman, M.D. ..... Maplewood
Charles H. Calvin, M.D. ..... Perth Amboy
John J. Bedrick, M.D. ..... Bayonne
Marcus H. Greifinger, M.D. ..... Newark
Daniel F. Featherston, M.D. ..... Asbury Park
Ralph M. L. Buchanan, M.D. ..... Phillipsburg
Louis F. Albright, M.D. (1964) ..... Spring Lake
Louis K. Collins, M.D. (1964) ..... Glassboro
Thomas C. DeCecio, M.D. (1965) ..... Cliffside Park
Joseph P. Donnelly, M.D. (1963) ..... Jersey City
Lloyd A. Hamilton, M.D. (1965) ..... Lambertville
Frank J. Hughes, M.D. (1963) ..... Gloucester
Joseph R. Jehl, M.D. (1963) ..... Clifton
Emanuel M. Satulsky, M.D. (1964) ..... Elizabeth
Carl N. Ware, M.D. (1965) ..... Ocean City

COUNCILORS

First District (Essex, Morris, Union, and Warren Counties) ..... Henry L. Hermann, M.D., Phillipsburg (1963)
Second District (Bergen, Hudson, Passaic, and Sussex Counties) ..... John L. Olpp, M.D., Englewood (1965)
Third District (Hunterdon, Mercer, Middlesex, and Somerset Counties) ..... Albert F. Moriconi, M.D., Trenton (1964)
Fourth District (Burlington, Camden, Monmouth, and Ocean Counties) ..... E. Vernon Davis, M.D., Moorestown (1963)
Fifth District (Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties).... Isaac N. Patterson, M.D., Westville (1963)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell, M.D. (1964) ..... Asbury Park
William F. Costello, M.D. (1963) ..... Dover
Joseph P. Donnelly, M.D. (1964) ..... Jersey City
Marcus H Greifinger, M.D. (1964) ..... Newark
Luke A. Mulligan, M.D. (1964) ..... Leonia
Isaac N. Patterson, M.D. (1963) ..... Westville

Alternates

F. Clyde Bowers, M.D. (1964) ..... Mendham
Frank J. Hughes, M.D. (1964) ..... Gloucester
Joseph R. Jehl, M.D. (1964) ..... Clifton
John F. Kustrup, M.D. (1964) ..... Trenton
Elton W. Lance, M.D. (1963) ..... Rahway
John L. Olpp, M.D. (1963) ..... Englewood

DELEGATES TO OTHER STATES

New York—William F. Costello, M.D. (1963) ..... Dover
Connecticut—Lloyd A. Hamilton, M.D. (1963) .. Lambertville
New York—G. Ruffin Stamps, M.D. (1963) .... Atlantic City
Connecticut—S. Eugene Dalton, M.D. (1963) ..... Ventnor

CHAIRMEN — 1962 - 63

Annual Meeting ..... Edward E. Seidmon, M.D., Plainfield
Cancer Control ..... John L. Olpp, M.D., Englewood
Child Health ..... Robert E. Jennings, M.D., South Orange
Chronically Ill and the Aging ..... Matthew E. Boylan, M.D., Jersey City
Constitution and Bylaws Revision ..... Louis F. Albright, M.D., Spring Lake
Credentials ..... Marcus H. Greifinger, M.D., Newark
Disaster Medical Services ..... Jack R. Karel, M.D., Hillside
Finance and Budget ..... Carl N. Ware, M.D., Ocean City
Hearing and Speech ..... James H. Spillane, M.D., Phillipsburg
Honorary Membership ..... F. Clyde Bowers, M.D., Mendham
Industrial Health ..... Delma W. Caldwell, M.D., Linden
Legislation ..... Jesse McCall, M.D., Newton
Maternal and Infant Welfare ..... John D. Preece, M.D., Trenton
Medical Defense and Insurance ..... Daniel F. Featherston, M.D., Asbury Park
Medical Education ..... Sherman Garrison, M.D., Bridgeton
Medical Services ..... Irving Klompus, M.D., Bound Brook
Medical Student Loan Fund ..... Luke A. Mulligan, M.D., Leonia
Mental Health ..... Robert S. Garber, M.D., Belle Mead
Nursing Education ..... Irving M. Levitas, M.D., Westwood
Physicians Placement Service ..... Samuel J. Lloyd, M.D., Trenton
Publication ..... Frank L. Rosen, M.D., Maplewood
Public Health ..... John B. Fuhrmann, M.D., Flemington
Public Relations ..... John F. Kustrup, M.D., Trenton
Rehabilitation ..... Elmer J. Elias, M.D., Trenton
Retirement Plan for Physicians ..... Nicholas E. Marchione, M.D., Vineland
Scientific Exhibits ..... Milton Ackerman, M.D., Atlantic City
Scientific Program ..... Herschel S. Murphy, M.D., Roselle
Traffic Safety ..... William L. Sprout, M.D., Salem
Vision ..... Samuel M. Diskan, M.D., Atlantic City
Woman's Auxiliary Advisory ..... Volmar A. Mereschak, M.D., Phillipsburg
Workmen's Compensation ..... Joseph A. Lepree, M.D., Elizabeth

In intestinal "grippe"

prompt 4 way check of diarrhea

- Curbs excessive peristalsis
- Adsorbs toxins and gases
- Soothes inflamed mucosa
- Provides intestinal antisepsis



POMALIN

TRADEMARK

Liquid

EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 cc. (tablespoon) contains:*

Sulfaguanidine U.S.P.	2 Gm.
Pectin N.F.	225 mg.
Kaolin	3 Gm.
Opium tincture U.S.P.	0.08 cc.
(equivalent to 2 cc. paregoric)	

DOSAGE: Adults: Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

Winthrop LABORATORIES
New York 18, N. Y.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.



SUPPLIED: *Bottles of 16 fl. oz. (raspberry flavor, pink color)*
Exempt Narcotic. Available on Prescription Only.

For your elderly arthritic patients



AN EFFECTIVE GERIATRIC ANTIARTHRITIC WITH DISTINCTIVE SAFETY FACTORS

safely indicated – even when **OSTEOPOROSIS** is present

PABALATE-SF, which has been found "superior to aspirin in the treatment of chronic rheumatic disorders,"[1] possesses distinctive **Safety Factors** for elderly arthritics, even when osteoporosis is present: (1) its potassium salts cannot contribute to sodium retention; (2) its enteric coating assures gastric tolerance; and (3) it does not produce the serious reactions often noted during therapy with steroids or pyrazolone derivatives.

In each persian-rose enteric-coated tablet: potassium salicylate, 0.3 Gm.; potassium para-aminobenzoate, 0.3 Gm.; ascorbic acid, 50 mg.

1. Ford, R. A., and Blanchard, K. P.: J.-Lancet 78:185, 1958.

Precaution: Occasionally, mild salicylism may occur, but this responds readily to dosage adjustment. In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Supply: Bottles of 100 and 500 enteric-coated tablets.

Pabalate®-SF

Robins

(the new, convenient way to prescribe Pabalate-Sodium Free)

A. H. ROBINS COMPANY, INC., RICHMOND, VIRGINIA

NOW! GREENWOOD FARMS

A new Community of Custom-Crafted Homes . . . in an Ideal Setting for Professional Office & Home!

Consolidate your practice and your residence in one of New Jersey's most desirable new suburban locations.

Masterfully designed, 3, 4 or 5 bedroom split level, ranch or 2 story colonial homes, ideal for accommodating large suites to suit your every professional need. Each home set back 100' on beautifully landscaped, minimum ¾ acre lots.

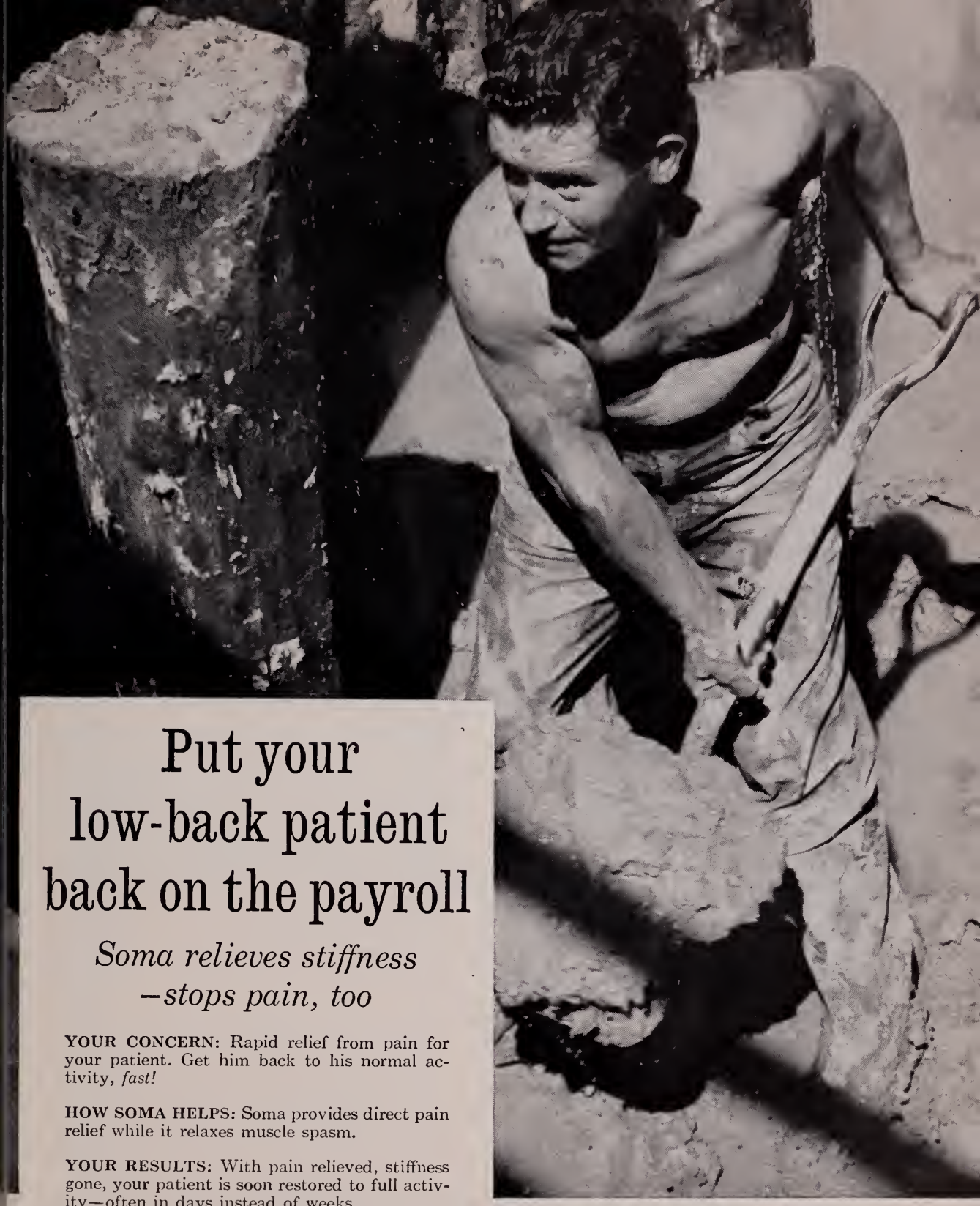
Diagonally opposite the forthcoming Bamberger Shopping Mall in Livingston, at the gateway to Short Hills, Millburn, Summit, South Orange, Madison and Morristown. Destined to become the hub of suburban Essex County, the location is accessible to all major roads and near the new Passaic Ave. Freeway extension to Morris Ave. Public transportation is just minutes away.

4 Models to Choose from . . . $32,900 to $41,500

GREENWOOD FARMS

WALNUT STREET AND ETON ROAD, LIVINGSTON, N. J.

DIRECTIONS: From Newark: South Orange Ave. west to Walnut St. (approx. 5½ miles past So. Orange Village); right turn to Eton Road and models.



Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, *fast!*

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

This was demonstrated by Kestler in a controlled study: average time for full recovery was 11.5 days with Soma, 41 days without Soma. (J.A.M.A. 172:2039, April 30, 1960.)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets.
USUAL DOSAGE: 1 TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey

Solfoton®

for mild, continuous sedation

Each tablet (or capsule) contains 16 mg. phenobarbital blended with 65 mg. Bensulfoid®. The Bensulfoid is an inert diluent present to permit slow absorption of the phenobarbital. The usual dosage is one tablet or capsule after meals and at bedtime. Solfoton is especially adapted to prolonged use because of its virtual freedom from depression and other side effects. Contra-indications: identical to those of ¼ gr. phenobarbital.

REFER TO PDR

Poythress, White Section, Page 808 (1963 edition) and Product Identification Section

COMPLETE INFORMATION AND CLINICAL SAMPLES SENT UPON REQUEST

Dispensed in bottles of 100 and 500 tablets or capsules

WM. P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856

indication:

accidental trauma



indicated:

Chymoral®

ORAL systemic anti-inflammatory enzyme tablet

92% Excellent/Good Results in 6,929 cases[1-4]

Whether the patient presents simple edema and inflammation from a sprained ankle or severe lacerations and bruises from a violent accident, immediate use of Chymoral cuts healing time. Chymoral modifies the inflammatory reaction, dissipates edema and blood extravasations, thus accelerating the body's natural reparative action.

controls inflammation, reduces swelling, relieves pain

1. Physicians' Reports to the Medical Department, Armour Pharmaceutical Company, 1961. 2. Beck, C., *et al.:* Clin. Med. *7*:519, 1960. 3. Teitel, E. H., *et al.:* Indust. Med. *29*:150, 1960. 4. Billow, B. W., *et al.:* Southwestern Med. *41*:286, 1960.

CHYMORAL is an ORAL anti-inflammatory enzyme tablet specifically formulated for intestinal absorption. Each tablet provides enzymatic activity, equivalent to 50,000 Armour Units, supplied by a purified concentrate which has specific trypsin and chymotrypsin activity in a ratio of approximately six to one. ACTION: Reduces inflammation of all types; reduces and prevents edema except that of cardiac or renal origin; hastens absorption of blood and lymph extravasates; helps to liquefy thick tenacious mucous secretions; improves regional circulation; promotes healing; reduces pain. INDICATIONS: Chymoral is indicated in respiratory conditions such as asthma, bronchitis, rhinitis, sinusitis; in accidental trauma to speed absorption of hematoma, bruises, and contusions; in inflammatory dermatoses to ameliorate acute inflammation in conjunction with standard therapies; in gynecologic conditions such as pelvic inflammatory disease and mastitis; in obstetrics as episiotomies and breast engorgement; in surgical procedures as biopsies, hernia repairs, hemorrhoidectomies, mammectomies, phlebitis and thrombophlebitis; in genitourinary disorders as epididymitis, orchitis and prostatitis; in dental and oral surgery as fractures of the mandible or maxilla, difficult or multiple extractions, and alveolectomies. CONTRAINDICATIONS: None known. INCOMPATIBILITIES: None known. Antibiotics as well as generally accepted measures may be coadministered. SIDE EFFECTS: Mild gastric upsets, rarely encountered. DOSAGE: Recommended initial dose is two tablets q.i.d.; one tablet q.i.d. for maintenance. SUPPLIED: Bottles of 48 and 250 tablets. Issue: Rev. Jan., 1963

The true economy of proven effective dosage

ARMOUR PHARMACEUTICAL COMPANY

KANKAKEE, ILLINOIS

Originators of Listica®

PROFESSIONAL LIABILITY INSURANCE PROGRAM

officially endorsed by

THE MEDICAL SOCIETY OF NEW JERSEY

PROTECTION for Professional Acts and Professional Premises Liability for members of The Medical Society of New Jersey by the First American Liability Insurance Company.

LOSS CONTROL. Your County Medical Review and Advisory Committee will evaluate malpractice cases and recommend the action which would be most favorable for the Medical Profession, the Defendant Doctor, the Patient and the Public. This program permits understanding of the complex problems involved in such cases and calls for close cooperation between the Medical Profession and Insurance Company.

MEDICO-LEGAL FORMS are furnished to each insured doctor to help in reducing claims or dissatisfied patients. Failure to use forms does not affect the doctor's insurance coverage or his eligibility for insurance.

INSURANCE COUNSELING. Insurance counseling and advice, available at all times, without cost, to help you with your Professional Liability insurance problems.

CANCELLATION. No policy will be cancelled or non-renewed without prior consultation between your Society and the Company and this is a matter of complete cooperation for the best interests of all concerned.

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY

Policies Guaranteed Non-assessable

Professional Liability Department

123 CLEVELAND STREET — ORANGE, NEW JERSEY

Joseph A. Britton, Manager — ORange 3-2575

Home Office: Wakefield, Mass.



"cleared head–able to breathe through nose"...or how another happy patient describes the nasal decongestant action of Dimetapp Extentabs.* How would your patients describe it?/In Sinusitis, Colds, U.R.I., up to 10-12 hours' clear breathing on one tablet (containing Dimetane® [brompheniramine maleate], 12.0 mg.; phenylephrine HCl, 15.0 mg.; phenylpropanolamine HCl, 15.0 mg.)./Also available: Dimetapp Elixir, for t.i.d. or q.i.d. dosage. **Dimetapp Extentabs**

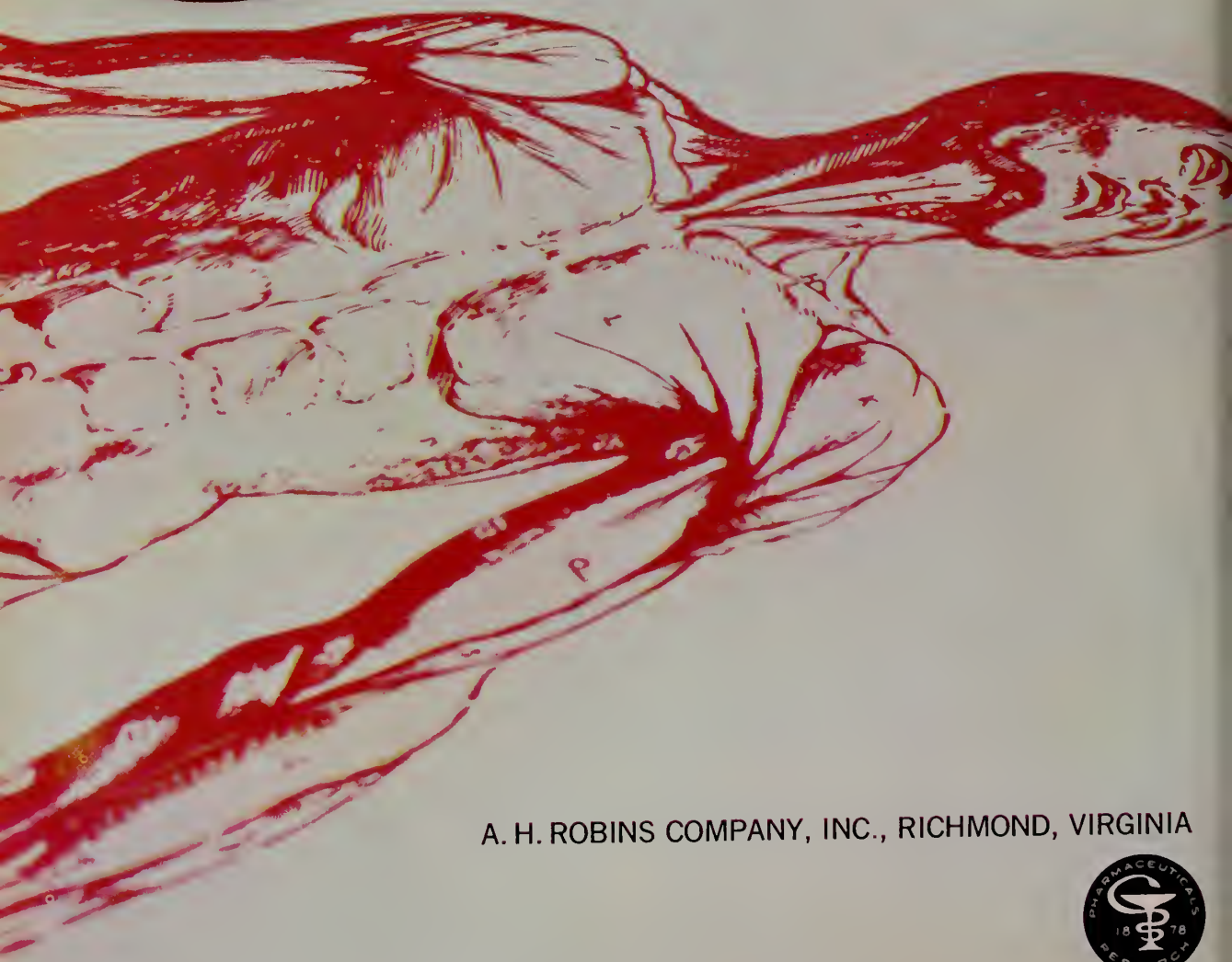
A. H. ROBINS CO., INC., RICHMOND 20, VA.

*Clinical report on file, Medical Dept., A. H. Robins Co., Inc.

A new, chemically different, skeletal muscle relaxant from Robins:

Skelaxin® brand of metaxalone for prompt relief of spasm





A. H. ROBINS COMPANY, INC., RICHMOND, VIRGINIA

PHARMACEUTICALS 18 78 RESEARCH

in acute sprains and strains

Because it acts so promptly, often within a few hours, Skelaxin is specifically recommended for the first treatment of acute muscle spasm associated with sprains and strains, fractures, dislocations, and other acute conditions. Results of clinical tests are impressive. In 595 patients with acute disorders, a favorable clinical response was observed in 507, or 85%.

For some of these patients, the onset of relief from pain was exceptionally prompt. Also, the average recovery time of good-or-excellent-response patients (among those whose recovery time was noted) was just over three days.

How Skelaxin works...

Metaxalone has been studied pharmacologically since 1958. Clinical trials began about a year later. These investigations indicate that Skelaxin blocks reflex spasm and spasticity by suppressing nerve impulses in polysynaptic pathways, primarily in the spinal cord and to a lesser degree at supraspinal levels. It helps restore normal muscle tone without altering posture or gait and without producing sedative, hypnotic, or tranquilizing side effects.

For your prescription...

Robins' metaxalone is available in 400-mg. tablets, in bottles of 50 and 500 tablets.

Skelaxin® metaxalone, 400 mg. per tablet

A. H. Robins Company, Inc., Richmond, Va.

prescribing information:

dosage: For Skelaxin, two tablets t.i.d. or q.i.d. for not longer than 10 days. Dosage for children (6 to 12 years) should be adjusted according to body weight.

side effects: In 1502 patients given daily doses of Skelaxin ranging from 1200 to 9600 mg., 10.5% experienced side effects. These were generally mild, with nausea or gastrointestinal upset being most frequent. Only 0.5% experienced vomiting attributable to the drug, however. Other effects infrequently noted were drowsiness, dizziness, headache, nervousness or "irritability," and a hypersensitivity reaction of light rash. All cleared promptly upon withdrawal of the drug.

precautions: Variations in white cell count and hemoglobin levels have been reported in a few patients. Therefore Skelaxin therapy for more than 10 days is not recommended. A drug relationship was indicated in one of four cases of leukopenia reported in 360 Skelaxin-treated patients. In all cases followed-up, the WBC returned to normal after discontinuance of Skelaxin.

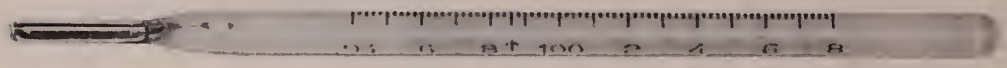
One instance of hemoglobin depression (less than 10 Gm.) which may have been drug-related was reported, in 306 patients; a return to an essentially normal level followed the discontinuance of medication.

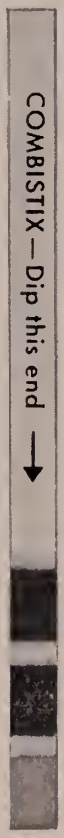
One case of jaundice has been reported. Elevation of cephalin flocculation tests in several instances were not paralleled by changes in other liver function parameters. Urinalyses in 280 patients were essentially normal; false positive Benedict's tests, due to an unknown reducing substance in the urine, were reported in 9 patients.

contraindications: Do not administer to patients with known tendency to drug-induced anemia, or give to them only under careful supervision. Not recommended for use during pregnancy.

Robins

one answer... three minutes





three answers ...ten seconds

DIP AND READ

combistix®

urine protein • glucose • pH

BASIC COMBINATION TEST FOR BEDSIDE AND OFFICE

. . . faster than taking temperature. Detects glucosuria (as in diabetes), proteinuria (as in renal disorder), abnormal pH (as in calcinosis or GU infection). For routine screening of all patients. COMBISTIX—*basic as the stethoscope.*

AMES products are available through your regular supplier. 38263

AMES
COMPANY INC
Elkhart • Indiana
Toronto • Canada



Now! Obtain patient cooperation by...

taking the deprivation out of dieting!

Even 700 calories per day lets patients enjoy delicious meals with MOTT'S FIGURE CONTROL FOODS!

Here is a new kind of diet you can offer patients—familiar, tasty foods of excellent quality, for meals that are a pleasure to eat, yet low in calories, fat and carbohydrates.

The 60 Mott's Figure Control Brand Foods were developed to fit the most broadly-accepted and proven diet concept. They offer a prudent diet, reduced in calories an average of 50%, mostly through the reduction of hard fats (the saturated type), and carbohydrates. A patented non-caloric sweetener is used in the extra-fine quality fruits and desserts, providing satisfying sweetness without extra calories. Natural fruit sugars remain intact.

Patients on low-cholesterol diets may now enjoy low-fat beef dishes, ready to heat and eat. Where additional polyunsaturates are indicated, you may wish to suggest adding polyunsaturated oils to the sauces. Those patients who need drastic calorie reduction in carbohydrates will find it in Figure Control Fruits, Juices, Preserves and Desserts.

Calorie counts as well as carbohydrate, protein and fat proportions of each product appear on its Figure Control label. The wide variety of Figure Control Foods at local supermarkets makes meal planning easy for patients.

MOTT'S FIGURE CONTROL® BRAND FOODS
CUT CALORIES, FAT AND CARBOHYDRATES!

HERE ARE TYPICAL 700 CALORIE PER DAY MENUS

BREAKFAST: Figure Control Breakfast Drink, high in Vitamin C, Farina with Figure Control Preserves or Maplette Syrup, Coffee with Figure Control Sweetener.
Calories—**about 95.** "Regular" food calories would be **about 235.**

LUNCH: Figure Control Fruits with Cottage Cheese, Figure Control French Dressing **or**
Figure Control Chopped Chicken Livers on Rye Bread Slice with Cole Slaw, Figure Control Whipped Dressing.
Black coffee or tea with Figure Control Sweetener.
Calories—**about 220.** "Regular" food calories—**about 400-600.**

DINNER: Shrimp in Figure Control Spaghetti Sauce, Figure Control Chicken a la King **or** Figure Control Braised Beef and Vegetables. Salad with Figure Control Italian Dressing, Figure Control Pears with Figure Control Chocolate Topping. Black coffee or tea with Figure Control Sweetener.
Calories—**about 350.** "Regular" food calories would be **about 720.**

NOTE: For more gradual weight loss, reduce calories daily by substituting two or more Figure Control Foods for "regular" foods in menus.

For your free jar of Figure Control Foods plus easy menu guidance for patients use this handy order form:

FIGURE CONTROL FOODS
Duffy-Mott Company
370 Lexington Avenue
New York 17, New York

Please send free jar of Figure Control Foods together with _____ free copies of Your Weight Control Plan.

Dr._____

Address_____

City_____Zone___State_____

E
ACHROMYCIN®

Tetracycline Lederle

R

ACHROMYCIN Ear Solution concentrates the potent activity of tetracycline for effective local anti-infective action. It is especially useful in otitis externa due to mixed organisms. Patient antibiotic intolerance and tissue toxicity are minimal. ACHROMYCIN Ear Solution is effective against both Gram-positive cocci and Gram-negative bacteria.

ACHROMYCIN Ear Solution: Each unit contains 1 bottle Powder, 50 mg.: 1 bottle Diluent (benzocaine 5% solution in propylene glycol)

When oral therapy is indicated

ACHROMYCIN® V

Tetracycline HCl with Citric Acid Lederle
Capsules—250 mg., 100 mg.



Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

RELIEVE THE COLD SUPPRESS THE COUGH WITH NEW

'EMPRAZIL-C'

TABLETS

ANTITUSSIVE ▪ DECONGESTANT ▪ ANALGESIC

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Acetophenetidin	150 mg.
Aspirin (Acetylsalicylic Acid)	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming.

Complete literature available on request.

Also available without codeine as

'EMPRAZIL'®

TABLETS



BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.

Webcor Music Man

STEREOPHONIC HIGH FIDELITY TAPE RECORDER

...the ultimate in tape recorder performance!



PRICED AT only $198.80

- 2 and 4 track stereo operation
- 3 speeds—1⅞, 3¾, and 7½ ips.
- New, simplified "push-lever" operation
- Self-contained stereo record and playback
- Digital tape counter with pushbutton reset
- Dual volume controls—one for each channel
- Dual bass and treble controls

If you're the "one in a hundred" with a highly critical ear for perfection in sound, you'll be satisfied with nothing less than the new Webcor "MUSIC MAN" stereo tape recorder. And it's ever so simple to operate! Just push the lever up to "Play"... push it down to "Stop"... move it to the left to "Rewind"... to the right for "Fast Forward." Treat yourself to a thrilling new hearing experience. Ask for a demonstration today at—

Write for catalog to Exclusive N. J. Wholesale Distributors

ALL-STATE DISTRIBUTORS

INCORPORATED

457 CHANCELLOR AVE. NEWARK, N. J.

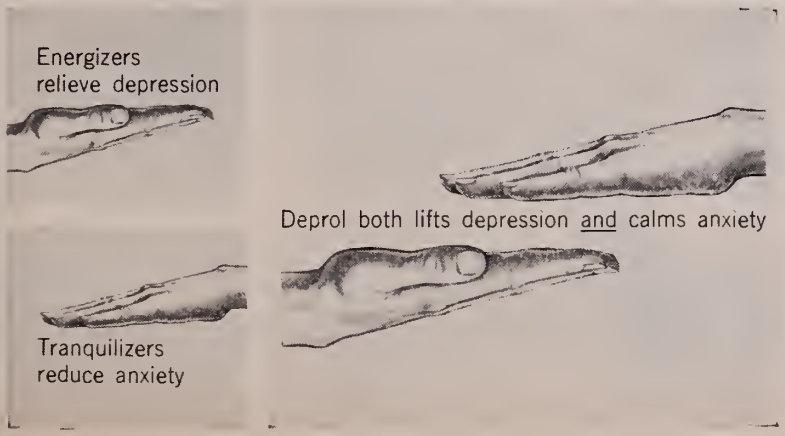
WAverly 3-4900

LIFTS DEPRESSION ...AS IT CALMS ANXIETY



"I feel like my old self again!" Balanced Deprol therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

Brightens mood...relaxes tension



Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be increased gradually up to 3 tablets q.i.d. With establishment of relief, the dose may be reduced gradually to maintenance levels.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets.

Write for literature and samples.

Deprol®

WALLACE LABORATORIES
Cranbury, N. J.

CD-7393

SENIOR CITIZENS



FULFILLING A RESPONSIBILITY VOLUNTARILY

THE BLUE SHIELD NATIONAL SENIOR CITIZEN PROGRAM has become a reality in New Jersey — thanks in large part to the cooperation and support of The Medical Society of New Jersey.

In endorsing the program, and the formula establishing lower Blue Shield fees for services rendered elderly persons of modest means, the Society struck a strong blow for the preservation of the voluntary system of medical practice. But the battle is not yet won.

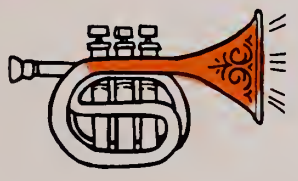
For the Senior Citizen Program to prove that the voluntary system can indeed carry this burden will require unremitting effort by the profession in partnership with the Plan, not without some sacrifice. Medical-Surgical Plan knows that it will continue to receive this whole-hearted support from the profession — and for its part, is proud to provide the vehicle through which organized medicine registers its willingness to continue helping the less fortunate — voluntarily!

BLUE SHIELD®
for Doctor Bills

Medical-Surgical Plan of New Jersey

EVERYBODY DOES IT





Toot! We have a nice little bargain, too...

Accustomed as we are to talking about purity, potency, stability, things like that, we thought you might like to know that mothers can make a nice saving on Vi-Daylin Chewables for the next few weeks. Nothing complicated. She buys a bottle of 100 at the regular price. She gets a bottle of 30 free. Big deal? Well, not a bad one. It means she's getting her Vi-Daylin for less than 3¢ per daily dose per child. You might find some vitamins somewhere that would cost even less. But will the youngsters take them?



ABBOTT
75TH

These Chewables Taste as Good as They Look

(AND THEY'RE SUGAR-FREE, THANKS TO SUCARYL®)

'irst cousin to an orange. Next door neighbor ɔ a lemon – that's new VI-DAYLIN® CHEW-BLE with *Entrapped* Flavor.

They look like footballs and smell like andy and you've never tasted a chewable itamin quite like them. What surprises you ; not so much what you taste as what you *on't* taste. Vitamins. They simply don't ome through – either in taste or ftertaste. Even the riboflavin ; trapped and civilized.

Our dual coating process does it – seals the raw vitamin tastes, protects the delicate flavoring agents. Releases the sweet citrus flavor in the mouth, the vitamins in the g-i tract. With *both* vitamins and flavors entrapped, there's just no chance of the tablets turning musty in the bottle.

Rational formula. And sweetened with sugar-free SUCARYL.

If they look good to you, imagine what youngsters will think.

75TH ANNIVERSARY ABBOTT



UCARYL – Abbott's Non-Caloric Sweetener.

asthma attack averted
. . . in minutes

patient protected
. . . for hours





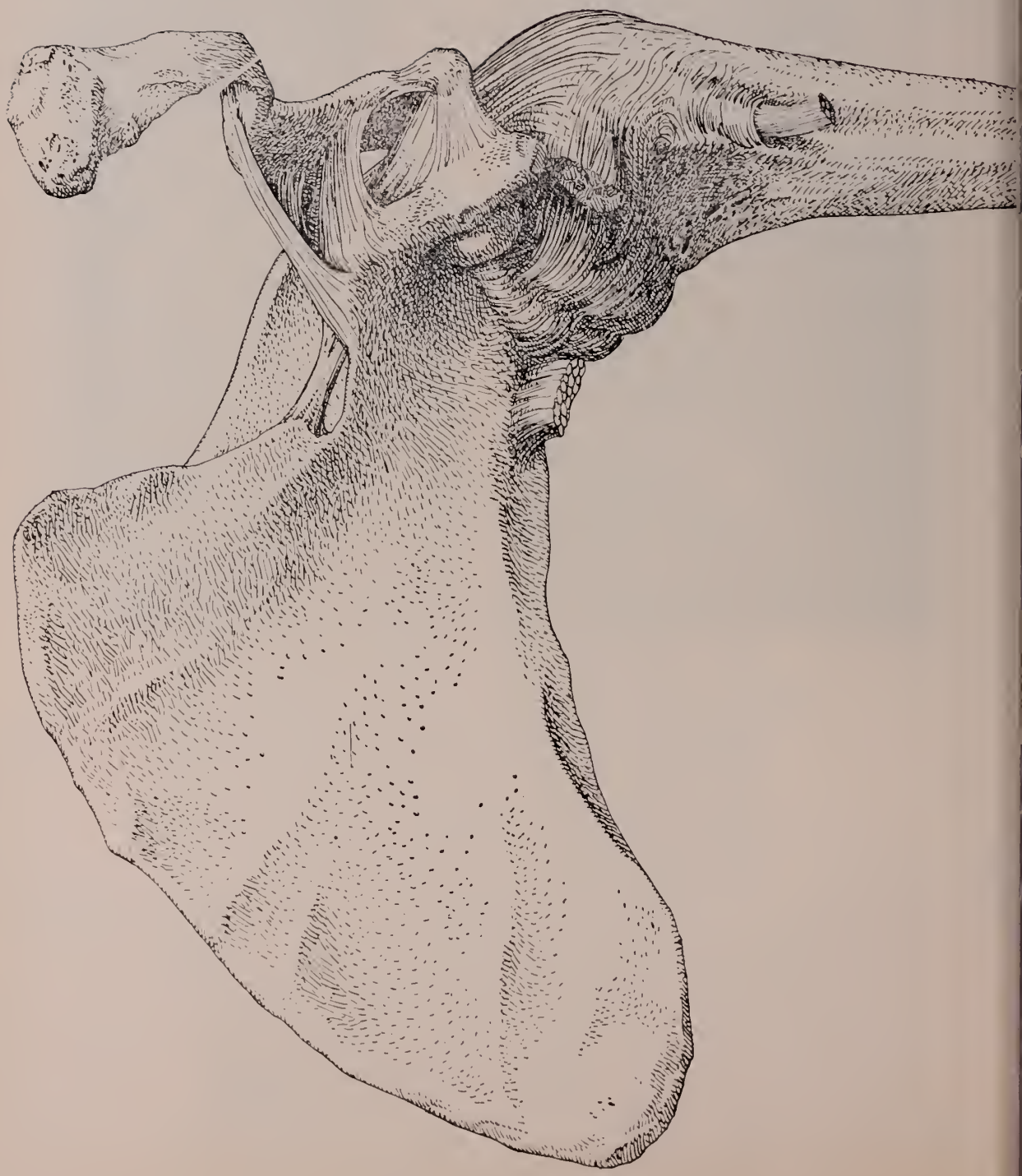
Nephenalin®

(the dual-action anti-asthmatic tablet)

. . . works with nebulizer speed—provides four-hour protection

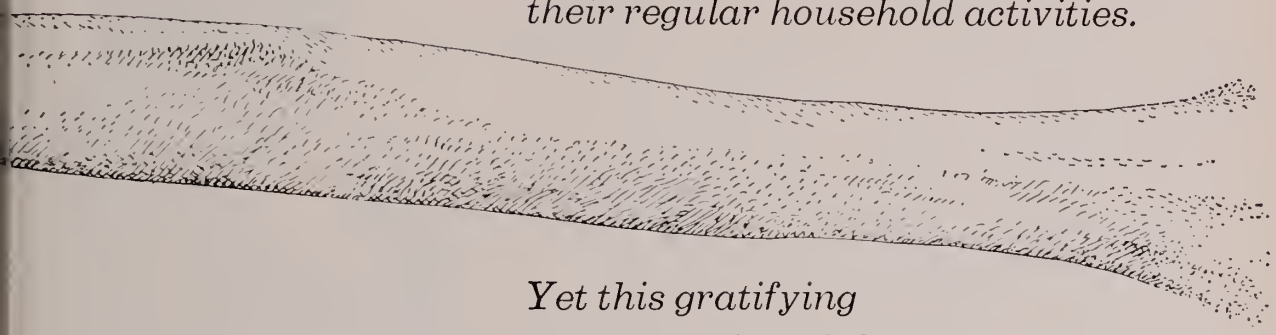
One NEPHENALIN tablet provides: *air in a hurry*—through sublingual isoproterenol HCl, 10 mg. *air for hours*—through theophylline, 2 gr.; ephedrine, 3/8 gr.; phenobarbital, 1/8 gr.
Dosage: Hold one NEPHENALIN tablet under the tongue for five minutes to abort the asthmatic attack promptly. Then swallow the tablet core for four full hours' protection against further attack. Only one tablet should be taken every four hours. No more than five tablets in 24 hours.
Supplied: Bottles of 50 tablets. For children: NEPHENALIN Pediatric, bottles of 50 tablets.
Caution: Do not administer NEPHENALIN with epinephrine. The two medications may be alternated at 4-hour intervals. NEPHENALIN should be administered with caution to patients with hyperthyroidism, acute coronary disease, cardiac asthma, limited cardiac reserve, acute myocardial damage, and to those hypersensitive to sympathomimetic amines. Phenobarbital may be habit forming. THOS. LEEMING & CO., INC., New York 17, N.Y.

gratifying relief fo



painful joints

With ARISTOCORT, *patients with painful, arthritic joints obtain rapid reduction of pain and inflammation, as well as substantial improvement in joint mobility. Many patients who might otherwise be confined in a state of invalidism have been able —with* ARISTOCORT—*to continue their customary livelihoods or go about their regular household activities.*



Yet this gratifying symptomatic relief may not be accompanied by severe hormonal collateral effects, such as sodium retention, edema, emotional disturbance, insomnia or voracious appetite—that may prevent patients from obtaining corticosteroid benefits.

unsurpassed for total patient benefits

Aristocort®

Triamcinolone Lederle

SUPPLIED: Scored tablets (three strengths), syrup, parenteral and various topical forms. Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York

Colds haven't changed— but relief has with NTz® NASAL SPRAY

NTz Nasal Spray gives on-the-spot relief for stopped-up noses instantly. Recommended by doctors for 10 years, it provides not one, but three powerful ways to fast relief.

In a carefully balanced formula, NTz contains:

Neo-Synephrine® HCl to shrink swollen nasal tissues and provide enough space for breathing

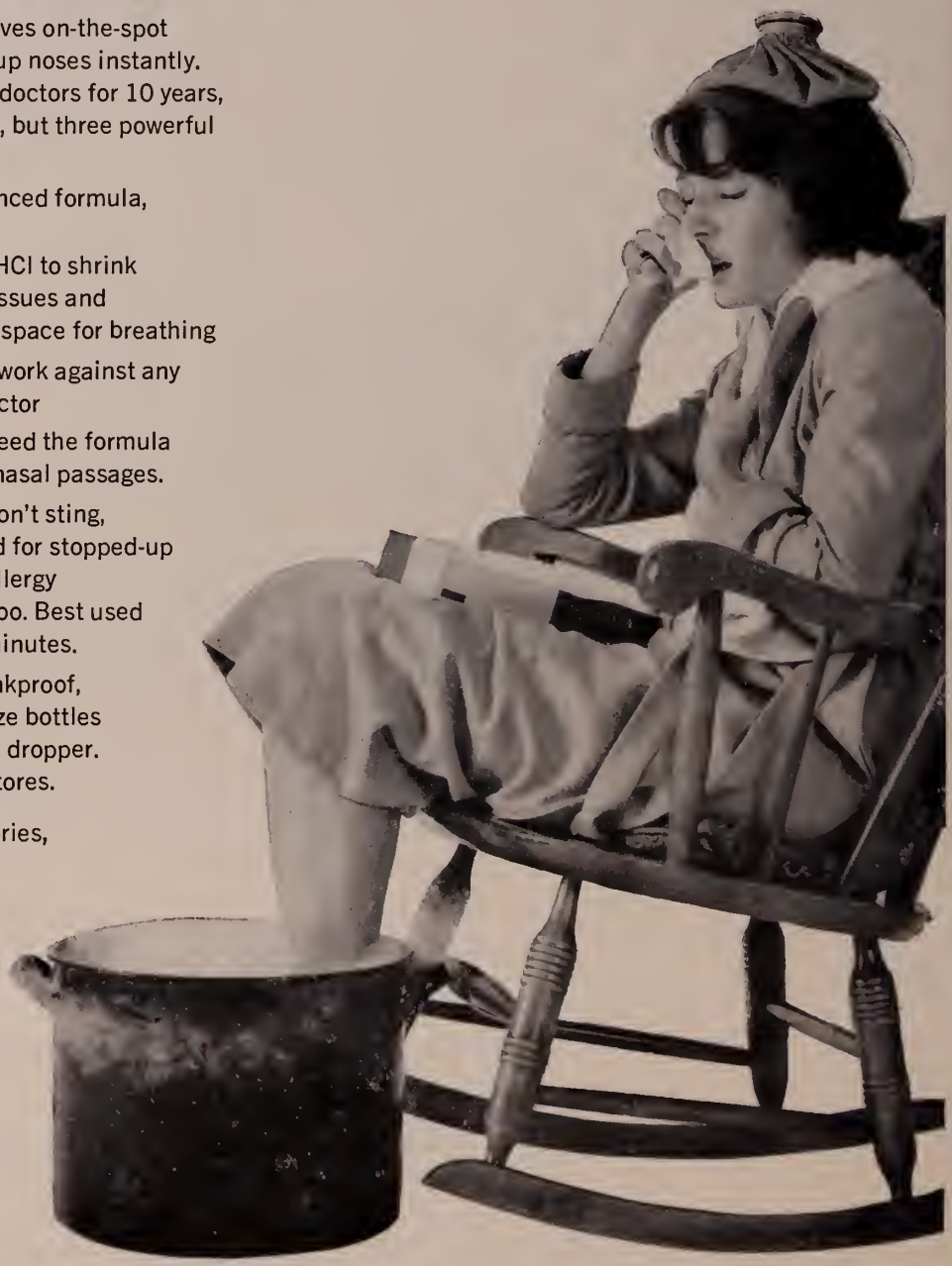
Thenfadil® HCl to work against any local allergic factor

Zephiran® Cl to speed the formula through **all** the nasal passages.

NTz Nasal Spray won't sting, won't irritate. Good for stopped-up noses caused by allergy and for sinusitis, too. Best used **twice** within five minutes.

NTz supplied in leakproof, pocket-size squeeze bottles and in bottles with dropper. Sold only in drugstores.

Winthrop Laboratories,
New York 18, N. Y.



Winthrop

NTz, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U. S. Pat. Off.

this can contained an effective help for infant diarrhea; celiac syndrome; fat intolerance_



Pro contains Protein 41%; 14%; Lactose 35%. Avail- e in 1-lb. and 2½-lb. cans.

AND IT'S FREE

SEND ME MY FREE SAMPLE OF HI-PRO, 2 OZ. SIZE

Mail to: Jackson-Mitchell Pharmaceuticals, Inc.
10401 Virginia Ave., Culver City, California
Babying Americans since 1934

Name _____

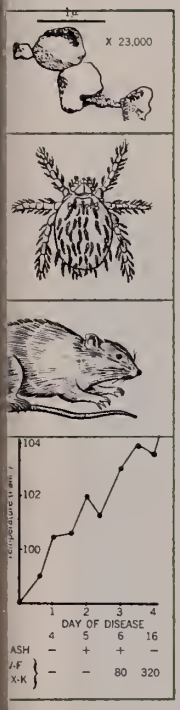
Address _____

City _____ Zone _____ State _____



from tsutsugamushi in Malaya to otitis media in New Jersey

here is a world of experience behind BRAND OF OXYTETRACYCLINE **Terramycin®**



Whether treating tsutsugamushi or a host of other infections, physicians throughout the world continue to rely on TERRAMYCIN for its outstanding safety, effectiveness and excellent tolerability. Not a single case of phototoxic reaction, blood dyscrasia or neurologic disturbance directly attributable to TERRAMYCIN has been reported in more than 3,000 clinical papers in the last 12 years. *In your practice, the next infection you see will very likely be "Terra-responsive."*

Tsutsugamushi, or scrub typhus, was responsible for incapacitating nearly 7,000 American soldiers during World War II. This disease is prevalent in areas overrun by jungle rats infested with mites carrying *Rickettsia tsutsugamushi.* Symptoms include a primary lesion at the site of the mite-bite, fever reaching as high as 105°, and a cutaneous rash. Injected conjunctivae, deafness, delirium and racking cough mark the advance of the disease. Mortality rates as high as 60 per cent have been reported. Terramycin is one of the antibiotics of choice for rapid and effective control of the acute stage of the infection. Patients become afebrile and virtually asymptomatic 24 to 36 hours after beginning treatment.

IN BRIEF The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. For complete information on Terramycin dosage, administration, and precautions, consult package insert before using. *More detailed professional information available on request.*

Science for the world's well-being®

Pfizer

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc.
New York 17, New York

but it can help you relieve the suffering of your patient in PAIN . . .

by reducing the anxiety and fear that intensify pain

by potentiating analgesics—enabling you to reduce narcotic dosage by 50 to 75%

and by controlling nausea and vomiting.

'Thorazine' is particularly useful in the severe pain seen in your cancer, surgical, and obstetrical patients. It is available in a wide variety of dosage forms, including injection, Spansule® sustained release capsules, suppositories, syrup and tablets.

For prescribing information, please see *PDR* or SK&F literature.

Thorazine® is not an analgesic

brand of chlorpromazine

SK&F *Smith Kline & French Laboratories*

Photograph professionally posed.



Bockus — Gastroenterology
Volume I — Just Published!

New (2nd) Edition! The first volume of this highly respected 3-volume work has been completely revised. The entire set of books will cover every known disease and condition of the gastrointestinal tract and associated organs. The author emphasizes a sound clinical approach to each problem, and carefully explains the causes and mechanisms responsible for each complaint. *Volume I* incorporates all important advances in therapy for diseases of the *esophagus and stomach*. New chapters are included on topics such as: *Oral Manifestations of Internal Disease; Tests Employed in the Study of Esophageal Function and Disease*. More than 150 pages are devoted to modern methods of diagnosis and management of peptic ulcer, with special emphasis on complications. A particularly significant new section shows endoscopic views of the esophagus and stomach, in magnificent color.

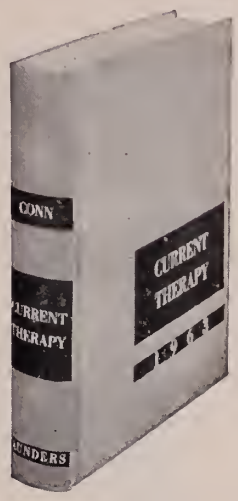
By HENRY L. BOCKUS, M.D., Emeritus Professor of Medicine, University of Pennsylvania Graduate School of Medicine. With Contributions by 31 Former and Present Associates of the University of Pennsylvania Schools of Medicine. Three Volumes totalling about 3000 pages, 7"x10", about 600 illustrations, some in color. *Volume I. Esophagus and Stomach.* 958 pages, 298 illustrations, $25.00, *Just Published. Volume II, ready August, 1963. Volume III, ready January, 1964.* *New (2nd) Edition!*

Meares — Management of the Anxious Patient

New! Here is a clearly written guide giving you specific instructions on managing patients suffering from anxiety or from disorders that may be based on emotional conflict or stress. Dr. Meares describes and explains the steps he uses in therapy. In a personal, informal presentation, devoid of esoteric jargon, the author tells you from what sources anxiety may spring. He shows you how anxiety can often be resolved without digging into your patient's past for childhood or infantile conflicts. He tells you *how to conduct the interview—how to elicit evidence of conflict—how to conduct the physical examination—how to use suggestion, drugs, etc.—how to avoid common treatment errors.* Dr. Meares describes the symptoms of anxiety as they appear in each body system. He also shows you how to manage anxiety in obstetrics, pediatrics and surgery.

By AINSLIE MEARES, M.D., D.P.M., Author of *The Medical Interview. A System of Medical Hypnosis, The Door of Serenity, Shapes of Sanity, Marriage and Personality, Hypnography,* and *The Introvert.* About 496 pages, 6"x9¼". About $9.00. *New—Just Ready!*

Today's Best Treatments



1963 Current Therapy

Here are the surest, most effective treatments known to medical science today for every disease you are likely to encounter. New and important changes in treatment for hundreds of diseases are detailed—diseases you may well be called on to treat within the year. Each is written specifically for *1963 Current Therapy* by an authority who is using it today.

This volume represents an extensive revision. Nearly 70% of the articles are changed in a significant manner. Among the 197 rewritten and revised articles you'll find: *Newer penicillins in the treatment of meningitis*—Treatment of whooping cough in the young infant—*Control of antibiotic-resistant staphylococci*—Newer knowledge of oral iron therapy—*Latest information on treatment of hepatitis*—Newest advice on treatment of adrenal insufficiency—*Action of sterols (Vitamin D and related agents)*—Management of conditions causing enuresis—*Relationship of hyperparathyroidism to urinary calculi*—Milk-alkali (Burnett's) syndrome—*Steroid spray in nickel dermatitis* — Elevated shoulder syndrome as a cause of headache—*Enzymes in management of postphlebitic syndrome* —Treatment of coma with analeptic drugs.

By 306 EMINENT AUTHORITIES Selected by a Special Board of Consultants. Edited by HOWARD F. CONN, M.D. About 864 pages, 8"x10½". About $13.00. *New—Just Ready!*

Order from W. B. SAUNDERS COMPANY

West Washington Square
Philadelphia 5

Please send me the following books and bill me: ☐ Easy Pay Plan ($5 per mo.)

☐ 1963 Current Therapy, about $13.00

☐ Bockus' Gastroenterology, Volume I, $25.00
☐ Send Volumes II and III when ready

☐ Meares' Management of the Anxious Patient, about $9.00

Name_____

Address_____

Saunders Books

SJG-2-63



together with an anti-atherogenic diet* to favorably influence serum lipid levels . . .

Each LUFA capsule provides:

Unsaturated Fatty Acids**	423 mg.
Pyridoxine HCl (B_6)	2 mg.
Choline Bitartrate	233 mg.
dl, Methionine	66 mg.
Inositol	40 mg.
Desiccated Liver	87 mg.
Vitamin B_{12}	1mcg.
Vitamin E (dl,alpha-tocopheryl acetate)	4 I.U.

**from specially refined safflower seed oil.
Provides approximately 329 mg. of linoleic acid.

patients with

HYPERCHOLESTEROLEMIA

ELEVATED SERUM LIPIDS

OBESITY

deserve the potential benefits of

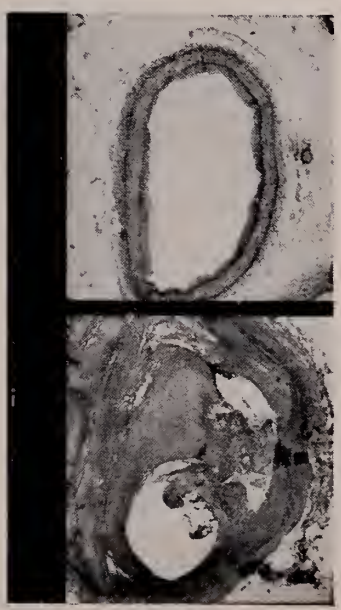
SAFE • SIMPLE • ECONOMICAL Lufa

plus an anti-atherogenic diet

1. The unsaturated fatty acids of Lufa and the anti-atherogenic diet help to offset the atherogenic effects of dietary saturated (animal) fatty acids.*

2. Lufa's lipotropic agents, by acting to prevent and treat fatty infiltration of the liver, help promote normal hepatic function, and may thus contribute to metabolism of cholesterol, lipoproteins and other lipids.

a major concept in control of atherosclerosis



dosage: Therapeutic, 6 to 9 capsules daily, in divided doses. Maintenance, one capsule b.i.d. or t.i.d.

supplied: Bottles of 100, 500 and 1000 capsules.

*Special anti-atherogenic diet sheets for patient distribution and LUFA samples and literature on request.

u. s. vitamin & pharmaceutical corporation
Arlington-Funk Laboratories, division
800 Second Avenue, New York 17, N. Y.

above: normal arterial lumen
below: extensive narrowing due to cholesterol

mudrane®

the bronchodilator
with the intermediate dose of KI

A combination of the four most widely used drugs for the treatment of asthma. Each Mudrane tablet contains Potassium Iodide 3 grains, Aminophylline 2 grains, Ephedrine HCl ¼ grain, Phenobarbital ⅓ grain . . . compounded for prompt absorption and balanced action, and buffered for tolerance.

Dispensed in bottles of 100 and 1000 tablets

WM. P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA
Manufacturers of ethical pharmaceuticals since 1856



Relieves Anxiety and Anxious Depressior

The outstanding effectiveness and record of safety with which Miltown relieves anxiety and anxious depression—the type of depression in which either tension or nervousness or insomnia is a prominent symptom — has been clinically authenticated time and again during the past seven years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more often than any other tranquilizer in the world.

Miltown®

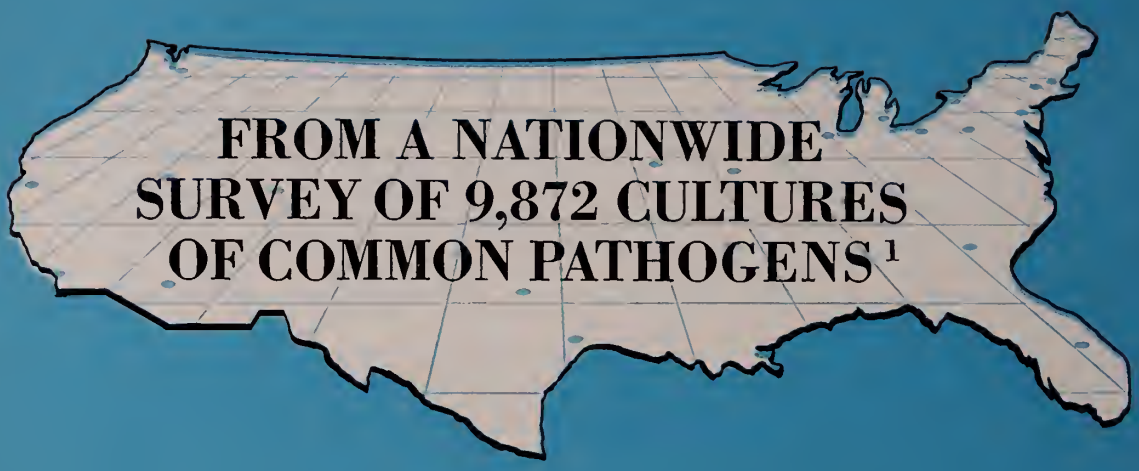
meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS® — 400 mg. *unmarked*, coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

WALLACE LABORATORIES / *Cranbury, N. J.*

Clinically proven in over 750 published studies

1. Acts dependably — without causing ataxia or altering sexual function
2. Does not produce Parkinson-like symptoms or liver damage
3. Does not muddle the mind or impair physical activity



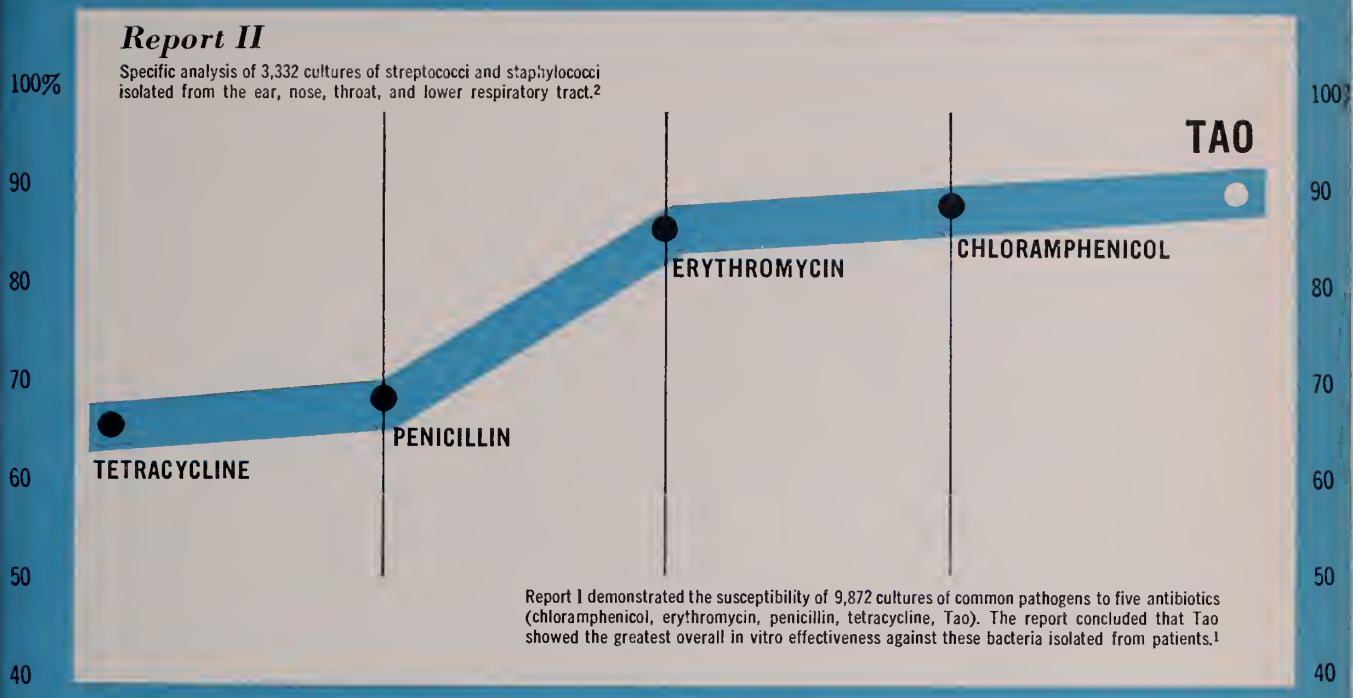
FROM A NATIONWIDE SURVEY OF 9,872 CULTURES OF COMMON PATHOGENS[1]

Conclusions of Nationwide Survey: *Report I*

1. **Even after five years of general use,** Tao, of the antibiotics tested, demonstrated greatest activity against respiratory streptococci and staphylococci (3,332 cultures).

2. **Overall results showed a higher percentage of susceptibility** among these common pathogens to Tao than to the other antibiotics. Susceptibility to Tao was greatest, not only in respiratory streptococci and staphylococci, but also in these organisms isolated from skin and soft tissue (3,423 cultures), genitourinary and gastrointestinal tracts and other sources (2,458 cultures). Susceptibility was equal to all antibiotics tested in pneumococci from unspecified sources (463 cultures), and less to Tao in H. influenzae from unspecified sources (196 cultures).

3. **Tao has been used for five years without development of predictable cross resistance.** In 1958 and 1961, approximately 73% and 70%, respectively, of erythromycin-resistant problem staphylococci showed susceptibility to Tao.[3,4] The present study confirms the continuing high degree of Tao activity even against these pathogens. Of 1,592 cultures of erythromycin-resistant staphylococci, 68% were susceptible to Tao, while in the reverse situation, only 33% of 768 Tao-resistant staphylococci were susceptible to erythromycin.



Report II

Results of Bacterial Susceptibility in 3,332 Respiratory Pathogens

References

1. "Bacterial Susceptibility Patterns: A Geographic Survey." Fowler, J. Ralph, M.D., and Watters, John L., M.D. Scientific Exhibit presented at the Annual Meeting of the American Society of Clinical Pathologists, Chicago, Ill., August 31 to September 9, 1962. 2. Fowler, J. Ralph, Watters, John L. and Levy, Arthur M.: Bacterial Susceptibility Patterns as Related to Geographic Variation and Anatomical Source. In press. 3. English, A. R., and Fink, F. C.: Antibiot. & Chemother. 8:420 (Aug.) 1958. 4. English, A. R., and Fink, F. C.: Antibiot. and Cbemother. 11:648 (Oct.) 1961.

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being®

If you would like a report of the entire susceptibility study, write Medical Department, J. B. Roerig and Company, 235 E. 42nd St., New York 17, N.Y.



Capsules · Ready-Mixed Oral Suspension · Pediatric Drops · Parenteral (as oleandomycin phosphate)



they never even had a chance to complain about the cost of drugs

Walk through any older cemetery, and you will find the same ugly story repeated many times. Died, age 30 years... died, age 8 years... died, age 6 months.

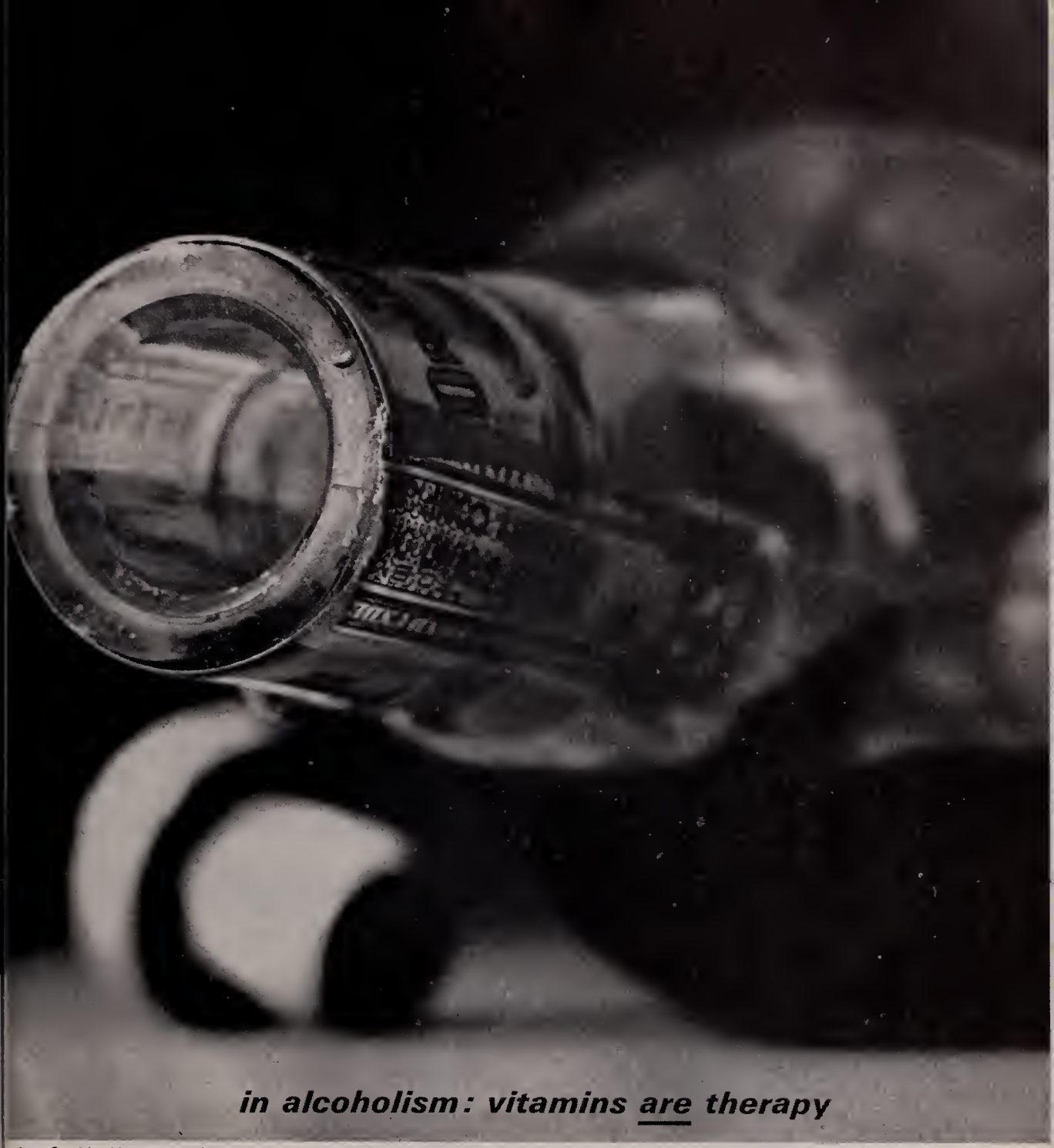
Sometimes, you will see evidence of entire families being struck down almost simultaneously. You wonder, was it influenza? Diphtheria? Infectious diarrhea? Or a host of other diseases whose very names were synonymous with terror?
You will see, "Died, age 22—childbirth."

There are many reasons why you don't see a continuation of these tragic stories today—not the least of which has been the dedication of American physicians and the quality of medical education. And another, we sincerely believe, has been the quality of medicines which have been made available.

Yet, the value of independent drug research has been seriously challenged—research which has, in the past 30 years alone, helped to add nearly 10 extra years to the average lifespan in the United States. Yet, because the cost of the search must be reflected in the price the patient pays for a prescription, is it too expensive to continue? Unfortunately, perhaps those who might have the best answer can offer only silent testimony.

This message is brought to you on behalf of the producers of prescription products.

A reproduction, for display in your waiting room, is available. Write:
PHARMACEUTICAL MANUFACTURERS ASSOCIATION • 1411 K STREET, N.W. • WASHINGTON, D.C.



in alcoholism: vitamins are therapy

A full "comeback" for the alcoholic is partly dependent on nutritional balance...aided by therapeutic allowances of B and C vitamins. Typically, the alcoholic patient is seriously undernourished...from long-standing dietary inadequacy, from depletion of basic reserves of water-soluble vitamins. Supplied in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

STRESSCAPS®

Stress Formula Vitamins Lederle

...WITH 'METHEDRINE' SHE CAN HAPPILY REFUSE!



Controls food craving, keeps the reducer happy — In obesity, "our drug of choice has been methedrine . . . because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent." Douglas, H. S.: West.J.Surg. 59:238 (May) 1951.

'METHEDRINE'®

brand Methamphetamine Hydrochloride

Supplied: Tablets 5 mg., scored. Bottles of 100 and 1000.

Literature available on request.

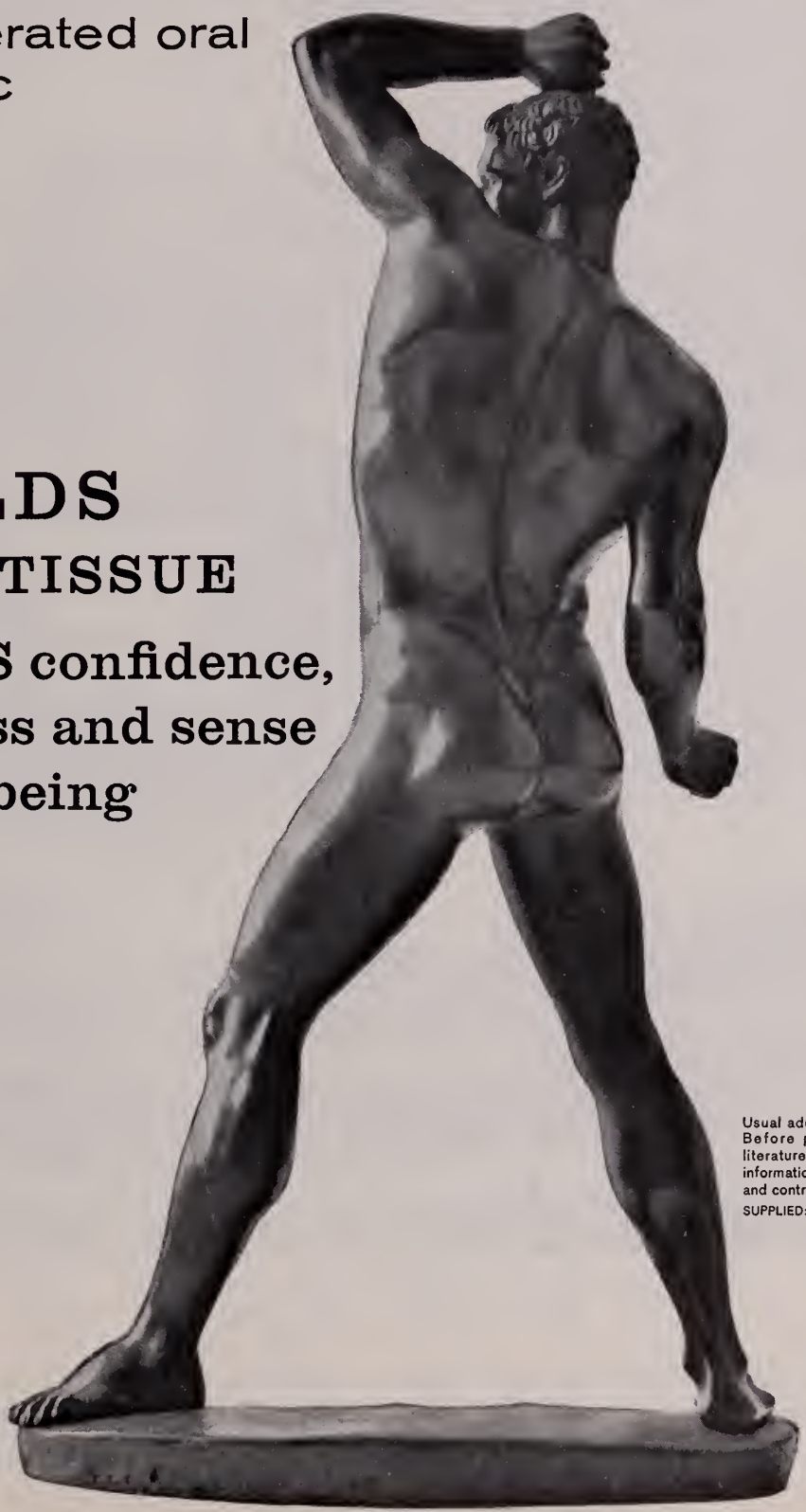
BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

THE SIGNIFICANT NEW PHYSIOTONIC

WINSTROL®

BRAND OF STANOZOLOL

well tolerated oral anabolic



BUILDS
BODY TISSUE

BUILDS confidence, alertness and sense of well-being

Usual adult dose: 1 tablet t.i.d. Before prescribing, consult literature for additional dosage information, possible side effects and contraindications.

SUPPLIED: 2 mg. tablets. Bottles of 100.

Winthrop
LABORATORIES
New York 18, N. Y.

ith WINSTROL, patients look better...feel stronger—because they are stronger



Cleanliness is more than a virtue at Lilly; it is a routine. It starts with vacuum-cleaning the drums filled with raw material even before they enter a Lilly warehouse. It is the first of an endless list of rules that have become a way of life for Lilly employees. Although meticulous housekeeping has little to do with technical know-how, it adds immeasurably to the quality of the finished product.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

190016

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

The Non-Equivalence of Equivalents

Talking about medicine doctors use technical language because it is more accurate, and medicine demands accuracy. But laymen often speak in terms that everybody can understand; though what they say is not always accurate.

We have recently witnessed an official display of inaccuracy as laymen talked about medicine. This was during the Kefauver subcommittee investigation of the prescription drug industry and continued in subsequent hearings on the Kefauver-Celler Bills (S. 1552, H.R. 6245). It was said that "generic equivalents" of brand-name drugs will give the American people the same top quality medicine as is offered today by brand-name drugs. Many citizens assume that this be true, and that the only question now to be settled is the kind of legislation needed to bring the supposed benefits of the generic "equivalent."

"Equivalent" is defined by its advocates as a product that is exactly the same as a trademarked product, although made by a different manufacturer. They want it sold under its generic name rather than a manufacturer's tradename.

The truth is that you cannot legislate such equivalents into being. Preparations of the same drug made by different manufacturers are almost certain to be different. Slight changes in production methods (such as differences in the size of particles, in the type of binders and of coatings) make marked differences in the drug's effect on the patient. And Levy and Nelson,[1] both professors of pharmacy, have published in the *Journal of the American Medical Association* an article nailing down the fact that generic "equivalents" may not be equivalent at all. They found that the difference between brands of the same drug is often "therapeutically significant" and that two drugs having the same active ingredients may affect patients in different ways.

Boger and Gavin[2] found that supposedly "equivalent" capsules of tetracycline, made by different manufacturers, produced greatly varying concentrations of chemical in the blood. The filler used by some companies had the effect of slowing down absorption of the drug. Morrison[3] reported that the amount of ribo-

PUBLISHED MONTHLY SINCE 1904

HENRY A. DAVIDSON, M.D., *Editor*

Under the Direction of the Committee on Publication
FRANK L. ROSEN, M.D., *Chairman*

THERESA E. GOEKE, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the Society is entitled to receive a copy of THE JOURNAL every month

Whole Number of Issues 702

VOL. 60, NO. 2 FEBRUARY, 1963 Single Copies, 30 Cents
Subscriptions, $3.00 per year

flavin absorbed by the body from eight different multivitamin tablets varied from 81 per cent of the labelled amount of riboflavin down to 14 per cent because of varying disintegration times of the tablets.

Keller [4] made a study of supposedly equivalent tablets of prednisone made by two companies. He found therapeutic differences of such magnitude that, when patients on product A were switched to product B, the healing process was reversed. Levy and Nelson [1] believe these differences to be due to variations in the method of producing the two products.

The therapeutic efficacy of a pharmaceutical product cannot always be determined merely by carrying out the applicable USP assay for the drug content. This is because most pharmaceutical products contain ingredients other than the active drug. The manufacture of these products involves mixing, compressing, coating, heating and filtering. Any of these operations, if improperly controlled, may affect the therapeutic performance of the preparation even though the assay will show no deviation of the drug content from "official standards."

Generic "equivalents" often are not equivalent.

1. Levy, Gerhard and Nelson, Eino: Journal of the American Medical Association, 177:689 (1961).
2. Boger, W. P. and Gavin, J. J.: New England J. Med., 261.827 (1959).
3. Morrison, A. B., Chapman, D. G. and Campbell, J. A.: Journal of the Amer. Pharm. Assoc., Scient. Ed., 48:634 (1959).
4. Keller, W.: *Die Pharmazie*, 15:56 (1960).

Pathology Dodo

The practice of pathology has changed considerably in 30 years. Today, national societies recognize governmental pathology, academic pathology, institutional pathology and the private practice of pathology. In each, dedicated individuals try to uphold the science and art of the practice of medicine. Organized medicine, however, has often failed to support these workers. Yet, as a professional group, these individuals have supported organized medicine to the letter.

One would have to lack all sensation to fail to realize that medical practice in this country is under constant criticism, active attack and vicious attempts to discredit its philanthropic activities by those who can see no beauty in anything unless it is government-controlled, subsidized or regulated, with added expense to the taxpayer.

Pathologists, because they constitute a small proportion of practicing physicians in the medical profession, have been out-shouted by the surgeons, clinicians, immunologists, bacteriologists, chemists and cytologists. It is conceivable, therefore, that those who would alter the practice of medicine should focus their attack upon its less vocal and poorly organized constituency. The practice of pathology is a well-roasted turkey for the socialized appetite.

Frontal attacks seldom achieve success and our opponents must be expected to utilize indirect approaches to all objectives. One of these is the exclusion of the laboratory service from the training program of the rotating internship. On the surface, this is an insignificant experimental change in the training program; yet, it will lead to tremendous repercussions in the future practice of pathology, and of all medicine in this country. The internship laboratory service of today cannot, in any sense, be compared or related to the laboratory service of even 20 years ago. It is the laboratory which has bolstered the bedside physician, with accurate differential diagnoses and confirmatory analyses. Absence of experience in these fields makes the practitioner a peddler of aspirin and penicillin.

Failure to interest the developing medical mind in the importance of pathology to the practice of medicine as a whole (or to any of its specialties) is a grievous error. Unless the embryo physician can be interested through the laboratory service in the specialty of pathology, he will not seek additional training as a resident pathologist, and thus can never become certified by Boards of Pathology examiners. Consequently, pathologists as a group will have been eliminated from the practice of medicine.

"Pathology is a dead subject." This lie has been parroted so frequently by surgeons, internists and clinicians that it is becoming accepted as a truth. Actually, the correlation of bedside bacteriology, immunology, hematology and biochemical physiology with anatomy constitutes one of the most active and often life-saving experiences that any practitioner of medicine may hope to achieve.

The pathologist is the work-horse of medicine. He assumes responsibility, yet receives little authority, for such duties as the provision of diagnostic services, training of technicians, training of residents and interns. He supervises the handling of the daily necropsy task. His opinion is frequently solicited for problem cases, which he is supposed to solve at a moment's notice and usually without compensation. He must provide examination material for all Board candidates in any specialty; but once the candidate has achieved certification, the specialty of pathology becomes a target for his derision. Actually, those who approve residency programs in institutions hold the pathologist accountable; but they report to the administration: a fine by-pass of the professional incumbent, through whose initiative the programs were instituted.

In 1960, there were in New Jersey, 41 approved residencies in pathology among 35 institutions. These facilities did some 6,000 necropsies and examined over 135,000 slides annually; yet we doubt that more than 50 per cent of these residencies were filled. In the past 15 years, the undersigned has personally trained five candidates in pathology; four of these were foreign-born. To date, four of the five have achieved Board certification and are practicing in the U.S.A. This basic fact would suggest that the field of practicing institutional pathology in this country will, in a short time, be controlled by persons who are not native-born individuals. Whether this will be beneficial to the specialty is problematical.

The rise of the "Director of Medical Education" in the institutional field is noted; that his achievements will ever equal those of the specialty of pathology is seriously doubted. Organized medicine has been an active participant in the financial extinction of the pathologist. The academic pathologist is supposed to dine on prestige. Will the subservience of pathology to the medical profession continue indefinitely? When pathology ceases to breathe its vitality into all phases of the practice of medicine, what becomes of medicine?

The practice of medicine is confronted with many problems and the specialty of pathology has not been exempt. Unless the present trend of downgrading pathology is quickly reversed and national organizations are willing to take positive steps in defense of their practitioners, this specialty of medical practice will become extinct.

The microbiologist, cytotechnologist, biochemist, lay director and, unfortunately, many of our medical brethren will dance happily on the dodo's grave. The dodo is, as you know, an extinct **bird.**

THOMAS K. RATHMELL, M.D.

How to Multiply Your Dollar: AMA-ERF

In these days of uncertainty, when it is often difficult to make plans far into the future, AMA-Education and Research Foundation is moving ahead with a Student Loan program that has its target set squarely in the long-term future: the future of American medicine. Its objective is to insure the quality of medical care for coming generations.

We know of few programs in which a comparatively small contribution can so dramatically promote the future welfare of so many Americans. A gift of $100 to the AMA-ERF Student Loan Fund will generate a bank loan of $1,250—enough to finance a medical student's training for half a year!

And the power of that $100 donation doesn't end there. When the medical student completes his training, he'll repay his debt and the $100 will return to the fund, where it can be available to help finance a medical education for another student.

Think of what a contribution of $1,000 could do if donated now. It could provide the financial aid to produce a new physician in 1970, another in 1977, in 1984, again in 1991, and in 1998. And the $1,000 would still be in the fund, ready to serve the cause of medicine again and again.

Physicians throughout the nation are being asked to contribute to this fund, which is now committed by loans made last year. Once again, Merck Sharp & Dohme has pledged $100,000 to be matched by individual physicians' donations. Do your share.

It is difficult to imagine a better way of putting dollars to work for the future of medicine.

ISAAC GELBER, M.D.

ROBERT L. LEWIS, M.D.

Elizabeth

Toxic Megacolon Complicating Fulminating Ulcerative Colitis*

Swift and bold surgery in toxic megacolon may be life-saving—as they were in this case from the Elizabeth General Hospital.

A PATIENT with chronic ulcerative colitis may suffer a toxic dilatation of the colon during an acute exacerbation of the disorder. This may occur during a first attack; or in the remitting-relapsing type of colitis. This is a serious complication, with a mortality rate as high as 30 per cent. While the older textbooks hardly mention it, several reports [1 to 12] have appeared in the last ten years.

We present here an additional case and offer some suggestions about combined surgical and medical management.

A 44-year old woman was first seen because of abdominal cramps associated with three to four loose stools daily. The stools contained blood, pus, and mucus. Onset was eight months earlier. Sigmoidoscopy disclosed a friable mucosa presenting numerous ulcerations and classified as grade III-IV ulcerative colitis. A barium enema (figure 1) was interpreted as showing diffuse ulcerative colitis.

The only significant laboratory finding was that of anemia. Her hemoglobin was 10.5 Grams.

On an ambulatory regimen including diet, steroids, and vitamin supplements she made a satisfactory response. But six months later, following an emotional upset, she developed severe abdominal pain, fever, nausea and vomiting. Diarrhea recurred. She then had five to six bloody stools daily.



Figure 1. Barium enema taken on admission. This shows loss of haustrations, fuzzy outline, and segmental narrowing, suggestive of ulcerative colitis.

She was then hospitalized. On admission, she was an acutely ill, toxic, dehydrated and prostrate patient. The abdomen was diffusely tender but soft.

*From the Departments of Gastro-enterology and Surgery, Elizabeth General Hospital, Elizabeth, New Jersey.

Her temperature was 100. Blood studies showed a hemoglobin of 9.4 Grams. White cells were 13,300 and 82 per cent of these were polymorphonuclears. Sedimentation rate was 83. She had a definite hypokalemia. Her serum potassium was 2.7 milliequivalents against a normal of 4 to 6. All other electrolyte values were within normal range.

She was placed on parenteral fluids and electrolytes with blood transfusions and intramuscular injections of 80 units a day of an ACTH preparation. We used the Armour brand, trade named ACTHAR Gel.®. There was visible improvement within 24 hours.

On the second hospital day she complained of localized pain at left upper abdomen radiating to the left shoulder. We found only moderate abdominal distention but no sign of peritoneal irritation; yet she seemed toxic, apprehensive and dehydrated.

Anticipating toxic megacolon and/or perforation, surgical consultation was obtained; and thereafter she was jointly evaluated daily.



Figure 2. A flat plate taken eight months after Figure 1. Note extreme dilatation of transverse and descending colon.

On the third hospital day, abdominal distention was markedly increased. A flat plate taken at this time confirmed marked dilatation of transverse and descending colon. See figure 2. We could see no free air, however.

It was significant that the amount of distention now resembled that seen in intestinal obstruction. This was true in spite of continued rectal passage of watery stools and gas. In addition to the distention there was increased tenderness especially over the transverse and descending colon.

The diagnosis of toxic megacolon complicating ulcerative colitis was made. Now was the time for surgical intervention.

She was prepared for surgery. In addition to antibiotics, blood transfusions, fluids and electrolytes the steroids were increased to 300 miligrams of cortisone during surgery and gradually tapered off during the postoperative period.

The abdomen was opened through a left rectus incision. The entire colon and part of the terminal ileum were markedly dilated. There was no fluid in the peritoneal cavity and no gross perforations. The diseased portion of the bowel started near the hepatic flexure and continued throughout the transverse and descending colon. The right colon appeared normal except for the marked distention present.

The friable nature of diseased bowel makes handling of the bowel difficult. Great care is always necessary to prevent perforation of the bowel during the operation. In this case, the bowel was deflated by suction placed through a stab wound in the relatively normal cecum. We noted that the distention was due almost entirely to gas, since very little fecal material was present.

A colectomy was done in the usual manner. The ileostomy stump was placed in the right lower abdominal quadrant. This left only about five inches of rectum to be removed at a later date.

Pathologic Report (See Figure 3): The gross specimen is 90 centimeters long. The wall of the transverse and descending colon is thickened. The mucosa is nodular, intensely congested, focally hemorrhagic and has a "pebble stone" (pseudo-polypoid) appearance. Between the areas of the pseudo-polyps the mucosa is denuded and there is occasionally a yellowish fibrinous deposition. The cecum and ascending colon are not remarkable. Ulcerative changes begin abruptly at the hepatic flexure. The diameter of the opened specimen in areas approximates 17 centimeters. Microscopically the mucosa is frequently ulcerated and between the areas of ulceration the mucosa shows a relative paucity of normal appearing glands. The muscularis mucosa is intermittently destroyed, though portions remain beneath the areas of residual mucosa. The chronic inflammatory exudate penetrates the entire thickness of the wall widely separating the muscle component.

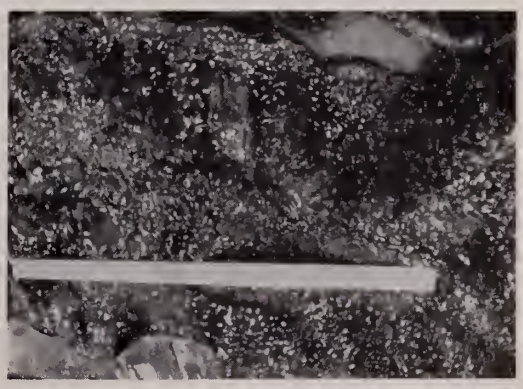


Figure 3. Opened segment of colon showing typical ulcerative colitis with pseudo-polyp formation. Note marked increase in open diameter.

353801

This exudate is composed of plasma cells, lymphocytes and polymorphonuclear leukocytes. The serosa shows infiltrations of similar inflammatory cells and some reactive fibrosis. *Diagnosis*: Chronic, ulcerative colitis.

The patient withstood surgery well. A marked improvement in her condition was noted in 72 hours. She was discharged on the fourteenth postoperative day asymptomatic and with normal hemogram.

This is the second instance of toxic megacolon in our experience in which ileostomy and colectomy were needed as life-saving measures during an attempt to induce remission by medical treatment. The other case was reported[2] in 1959.

At one time, we were all gloomy about colonic dilatation in the course of ulcerative colitis. This complication was considered an ominous one. Yet, in those days we seemed to have given no thought to the possibility of emergency surgery. And indeed, within recent weeks, we learned of two fatal cases of toxic megacolon in ulcerative colitis. Neither of these patients was given the chance of surgery.

Within the past ten years, 140 cases were reported where patients received either medical treatment alone, or medical care plus surgery. In general, examination of resected specimens shows extensive involvement of all layers of colonic wall in the inflammatory process with necrosis of muscularis and possibly the myenteric plexuses. In many cases the transverse and descending colon were thinned out by extensive necrosis leading to perforation and peritonitis.

It would be premature to draw a statistical conclusion about the superiority of one method of treatment over the other. However, a critical analysis of these reports reveals the following significant features:

Average time between onset of distention and surgery in Korelitz's series[9] was 8.7 days. Ten out of eleven cases survived surgery and went on to recovery.

Smith[10] reports eight surgical survivals, two deaths without surgery and one remission on medical treatment alone. Since he advocates a trial period of three to five days on medical treatment, it may be assumed that the lapsed time (between distention and surgery) was shorter than in Korelitz's cases. Lumb[8] cites four surgical deaths out of six cases operated upon. He gives a lapse of time of six, eight and 12 weeks between onset of distention and surgery. His fourth patient died of peritonitis and massive hemorrhage. She had been operated upon four days after appearance of distention.

McInerney's report[11] of 23 survivals out of 28 cases of colonic distention by medical treatment alone is impressive. His high surgical fatality rate, five out of eight cases, is also noteworthy. However, the degree of distention, severity of the disease and time lapse before surgery are not stated.

We conclude that surgery, preferably ileostomy with subtotal colectomy, should be tried after a few days if there is no response to medical treatment. As Almy[7] says, "Many of these patients are, indeed, too sick *not* to be operated upon," and the high surgical mortality rates were probably due to delayed surgery rather than to the operation.[10]

Anti-cholinergic drugs, barium enemas[3] and steroids[10] have been incriminated in initiating colonic distention in a few instances.

Corticosteroids are a valuable adjuvant. They should be continued during medical management. During surgery and in the postoperative period, the dosage should be increased, and then gradually reduced. This will prevent adrenal insufficiency and reduce surgical mortality rates.

Although no rigid criteria can be set down, we urge the joint evaluation by clinician and surgeon to decide when the time has come to save the patient by ileostomy and colectomy rather than to bury him with his diseased colon.

SUMMARY AND CONCLUSIONS

A CASE of toxic megacolon is reported in the course of an ulcerative colitis. This patient was successfully managed by a combination of medical treatment and operative surgery. The literature, here analyzed, suggests that total colectomy with ileostomy is the desirable surgical procedure.

712 North Broad Street

We thank our pathologist, Dr. Joseph P. Greeley, for his many excellent suggestions, for his assistance and for his expert review of the pathologic material.

BIBLIOGRAPHY

1. Rankin, J. G., *et al.*: Quarterly Journal of Medicine, 29:375 (July 1960).

2. Roth, J., *et al.*: Gastro-enterology, 37:239 (September 1959).

3. Marshak, R. H., *et al.*: Gastro-enterology, 38:165 (February 1960).

4. Wolf, B. S. and Marshak, R. H.: Journal of Roentgenology, 82:985 (December 1959).

5. Jones, L. and Vivian, A.: British Medical Journal, 2:6 (July 1960).

6. Bockus, M. L., *et al.*: Gastro-enterology, 34:549 (May 1956).

7. Almy, T. D.: Gastro-enterology, 41:391 (October 1961).

8. Lumb, G., *et al.*: British Journal of Surgery. 43:182 (September 1955).

9. Gelbe-, I.: Peruvian Journal of Teratology. 17:781 (December 1941).

10. Smith, F. W., *et al.*: Gastro-enterology. 42:233 (March 1962).

11. McInerney, G. T., *et al.*: Gastro-enterology 42:244 (March 1962).

12. Lancet editorial, 2:229 (August 6, 1960).

New Universal Calibre for Syringes

To facilitate interchangeability of hypodermic syringes and needles in emergency or disaster, the six per cent conical taper may soon be universally accepted throughout the world. This is the proposed international standard favored by a committee of the International Organization for Standardization (ISO). It will be submitted for balloting by the 44 member nations.

Meeting in Paris in December 1961, delegates from Britain, United States, France, Germany, Netherlands, Norway, Czechoslovakia and Poland agreed on dimensions and tolerances for the conical fitting used to connect hypodermic needles to syringes. The committee recommended dimensions for fittings having a 6 per cent taper, this facilitating interchange with those of the type already used in the U. S. and specified in American Standard Z70.1-1955. This action was based on the need for interchangeability of this equipment at times of national disaster when supplies are rushed from many different countries.

Noting the continued use of the 10 per cent conical taper in some portions of the world, the committee recommended that it be included on an interim basis in the ISO draft recommendation. This would not alter the goal of universal application of the six per cent taper.

In recommending standard sizes of needles and syringes, the committee seeks uniformity of size, whether designated in inch or metric dimensions. Seeking to reflect this interchangeability between inch and metric production, they proposed that packages of needles be marked in both dimensions—with diameter and nominal length in metric dimensions (the European practice) and in gauge size and nominal length in inches (the American practice).

Action by the 44 member-bodies of ISO on the committee's draft recommendation is expected in 1962. U. S. representation on the international standards project was provided through the American Standards Association. Committee chairman is E. W. Bednarz of Becton, Dickinson and Company, Rutherford, N. J.

Sidney S. Boyers, M.D.

West New York

Stapes Surgery*

Its History, Early Phases and Later Development

In this review of almost a full century, Dr Boyers gives a historical perspective on stapes surgery.

In the last quarter of the Nineteenth Century the medical field saw its initial sustained attacks on progressive non-suppurative deafness. This followed by about 25 years the knowledge that this type of deafness was due to a fixation of the stapes. Kessel,[1] in 1876, reported the resection of the tympanum and the removal of the malleus and incus. Results were discouraging. Even with later removal of the stapes, hearing was only temporarily improved.

Within the next ten years French, German and English surgeons were working on the problem of fixation of the stapes without much success. Boucheron,[2] in 1888 and Miot,[3] in 1890 reported some successful cases of restoration of hearing by direct pressure on the incudostapedial articulation.

Dr. Frederick L. Jack,[4] of Boston, in 1892, operated on a child, 12 years old, for chronic otitis media. He removed portions of the membrana tympani, malleus, and incus. Noting that the head of the stapes was carious Dr. Jack proceeded to remove it. Hearing improved following the operation. A year before, the French surgeon, Boltey,[4] had published an article on improvement of hearing in animals following removal of the stapes. Dr. Jack removed the stapes in 16 consecutive cases of loss of hearing. Twelve had had chronic suppurative disease of the middle ear, and three were chronic non-suppurative cases. Of all 16, only one was unimproved. The sixteenth case was classified as Menieres.

Dr. Jack made an inverted V in the drum membrane, just over the incudostapedial joint and allowed the cut portion to drop outwards. He then severed the stapedius muscle a short distance from the head of the bone. Dr. Jack then used a triangular knife bent in an obtuse angle to sever the long process of the incus. A small hook was next used to remove the stapes completely. In one case, where the foot-plate remained, the "bone" came away without suction. A year later, he reviewed[5] the original 16 cases and found essentially the same findings as were present previously post-operatively. In some the hearing had decreased slightly but in others it had improved. At this time, Dr. Jack also advised the removal of the incus in cases where it became markedly displaced following the separation of the incudo-stapedial joint. He recognized the fact in otitis media insidiosa (sclerosis), the foot-plate tended to remain behind in whole or in part, when the stapes removal was attempted. "This accident is at present unavoidable and insurmountable," he stated.

Blake,[6] in an article published in 1893, after 21 operations for chronic non-suppurative dis-

*Read at the "Symposium on Microsurgery of the Middle Ear," before the section on Otolaryngology, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 16, 1962.

ease of the middle ear, came to the conclusion that the operation of stapedectomy was "most likely to be futile because of the degree of fixation of the base of the stapes leading to fracture of the crura rather than the removal of the bone entire, if the effort of extraction is persisted in."

To determine adhesions and mobility of the stapes, an exploratory tympanotomy was routinely conducted first under local anesthesia in 18 cases. Three of the 21 stapes operations performed were followed by appreciable improvement in hearing. The procedure involved an incision in the superior-posterior quadrant of the tympanum which was carried to the periphery. The stapedius tendon and the incudostapedial articulation were divided and an attempt at "circumcision" of the stapes was attempted. In two of the successful cases the stapes disappeared from sight, and in one of these, the incus also disappeared.

SUMMARY OF DR. BLAKE'S CASES:

Number of cases of attempted removal of the stapes in chronic non-suppurative disease of the middle ear	21
Stapes removed entirely	9
Fracture of both arms	10
Stapes immovable in	2
Change of pulse incident to traction on the stapes	12
Vertigo	6
Vertigo persisting over one month	3
Improvement in hearing	3

No mention was made at that time of the fact that a columella to replace the stapes might be necessary to complete the sound conduction.

Later Dr. Jack[7] spoke of his experiences in stapes surgery after having done 60 cases. His conclusions reiterated his lack of confidence in expecting results in otosclerosis. Most operations for mobilizing the stapes or freeing the oval window, he suggested, should be looked upon as largely experimental. Then, in 1902,[8] he reported on a stapedectomy done ten years earlier:

"The eardrum had become adherent to the oval window following the stapedectomy. The patient, tested at 20 feet, had very good hearing of the spoken voice."

Politzer,[9] whose experiences with stapedectomy were also discouraging, believed that extraction of the stapes is easily performed if the footplate is movable in the fenestra vestibuli. If, on the other hand, the stapes is partly or totally ankylosed in the fenestra, the crura will be fractured even by the most careful extraction. Circumcision and loosening of the ankylosed footplate without injury to the labyrinthine contents are seldom successfully carried out, because the plane of the fenestra vestibuli is at such an inclination to the axis of the external auditory canal that the field of operation cannot be entirely surveyed. In this operation particles of the footplate may enter the vestibule, giving rise to a suppurative inflammation of the labyrinth which would destroy the endings of the acoustic nerve.

The technic advocated then by Politzer[9] always included general anesthesia; No skin flap was performed. "A perforation is first made in the posterior-superior quadrant of the membrana tympani, through which the incudostapedial joint becomes visible; the tendon of the stapedius and the incudostapedial articulation are then severed, and the stapes is removed with a small, delicate hook."

After several years of experience in extracting the stapes in otosclerosis, Politzer[9] felt that this operation had proved to be a useless therapeutic measure.

Kerrison,[10] in 1923, in his remarks on the surgical measures for otosclerosis, mentions three procedures:

1. The incudostapedial articulation is exposed by a horseshoe flap in the tympanum in the posterosuperior quadrant and the flap is folded downward. The head of the stapes is then moved in different directions without danger of injury to the annular ligament or of disarticulation from the incus.

2. Reduction of the abnormal ossicular tension by division of the tendons of the tensor tympani and stapedius muscles.

3. Removal of the membrana tensa, malleus, and incus, the stapes being left in situ. The idea was that the stapes, acting alone, may be permitted to receive the sound moves and transmit them.

Kerrison [10] believed that the best advice for a patient with otosclerosis was "that he apply himself diligently, under the advice of a competent teacher, to the task of acquiring the art of lip-reading."

Wendell Phillips,[11] one of the early leading consultants in New York City, thoroughly disapproved of the extraction of the stapes. He was concerned about the danger of infection of the labyrinthine canals, and said that the footplate was most often left *in situ* after fracturing the crura. This made the operation a distinct liability.

Massage of the eardrum was the procedure of choice at this time. This was accomplished by an apparatus which used water as a pressure medium on the tympanum. This was called pneumohydro-massage. A more refined massage was accomplished by the Siegel otoscope attached to a pump worked by an electric motor.

ANOTHER device in use in the 1920's, invented by Lucae,[12] was a spring pressure sound for breaking up ankylosis of the ossicles. This consisted of a probe, the end of which was fitted to a cup. The other end of the probe was attached to a handle, around which a spring worked. The cup was placed upon the processus brevis and the instrument pressed inward. The spring gave resistance and thus a graduated amount of force could be controlled. This instrument created much pain and often severe injury to the eardrum. Results were very varied.

Further progress in the surgery for otosclerosis seemed to end with the beginning of the twentieth century. Surgical advance had not proceeded beyond the removal of the stapes; and *status quo* remained until 1952.

On April 3, 1952, Rosen [13] attempted a better evaluation for suitability for the fenestration procedure in otosclerosis in one patient. Rosen used the approach for tympanosympathectomy which has since become the main avenue of entrance to the middle ear for mobilization technics. During palpation of the stapes his patient stated: "I can hear everything now." This statement became the impetus for the renewed investigations in stapes surgery. A year later, Rosen [14] described his technic of mobilization of the stapes. This was at first accepted generally around the world, although with reservations by many of the otologists.

The operation was done under local anesthesia using a speculum in the external auditory canal. A Zeiss binocular loupe, about 2.5-X magnification, was used. The approach was the one used for sectioning the chorda tympani nerve. The skin of the bony canal wall was resected posteriorly, six or seven millimeters external to the drum. This was then separated medially and flapped anteriorly together with the freed posterior portion of the eardrum. A probe was then used with downward pressure on the capitulum. If mobilization was not successful, a mobilizer was placed on the anterior neck of the stapes and pressure was applied posteriorly in the line of the tendon.

In 1955 Rosen [15] reported evidence of hearing improvement, following mobilization of the footplate of the stapes, that had already been maintained for two years.

In accounting for his failures in stapes mobilization Rosen [15] listed these:

1. An extreme degree of fixation of the footplate.
2. Fracture of the crura.
3. Faulty technic.
4. Unknown factors.

Despite the good restoration of hearing in many patients with otosclerosis who had the mobilization of the stapes accomplished, reports now began to appear which showed as many failures as successes. Also some patients who had been helped by the mobilization were now complaining of a regression in their hearing.

Scheer [16] evaluated his results of mobilization of the stapes in 50 patients. His technic was basically that of Rosen.[13] Three stapes were found mobile at the time of surgery; 16 had their crura fractured, and 31 stapes were successfully mobilized. Of these 31, fif-

teen showed marked improvement in hearing and sixteen had little or no improvement. Two of the markedly improved cases had a regression in hearing. Remobilization in these two cases was successfully done.

In 1954, Meurman and Meurman [17] mentioned the increased visibility available in mobilization surgery, by using the Zeiss Binocular microscope. They used magnification of 6X, 10X, and 16X. This was a Finnish report, not published in this country until a year later.

In 1956, Bellucci [18] expressed the sentiment of his colleagues when he stated that the large proportion of failures was principally due to poor visualization of the stapes and oval window.

The general use of the binocular microscope for stapes surgery occurred in the immediate months ahead. This period now led to marked strides in the advancement of the surgery for stapes fixation. The increased visualization meant an increase in the attack on the fixed footplate of the stapes and the development of more refined technics.

Rosen [19] reported the "direct method" of mobilization in which a sharp pointed explorer was gently wedged between the bony margin of the oval window and the peripheral margin of the stapedial footplate. This was an attempt to mobilize the footplate itself. No effort was made to enter the vestibule. Then, a year later, Rosen [20] deliberately made openings into the vestibule in cases in which mobilization was unsuccessful. This was done at the time of operation. The fenestra was made at the inferior rim of the footplate and was half the size of the head of a pin.

In 1956, Kinney,[21] read from a questionnaire he had requested, that Kos and House were now using a small pneumatic hammer. This hammer produced a series of blows to parts of the rim of the footplate in cases where a fracture of the crura had occurred. House [19] reported that with this method he could mobilize at least part of the footplate in 95 per cent of his cases.

In an attempt to develop a greater proportion of success in mobilizing the stapes, Myerson,[22] used a forked instrument to fit over the incudostapedial articulation. A revolving rod, inserted into a dental handpiece, was brought into contact with the forked instrument. Using speeds of 1500 to 9000 revolutions per minute, vibrations of varying intensity were produced. Myerson stated that if this technic and direct mobilization were unsuccessful, then fenestration was the procedure of choice. Shortly thereafter, Shea [23] mentioned a case in which he removed the stapes, fenestrated the oval window, and laid a .005 inch thick skin graft over the window. He then placed an artificial stapes, made of nylon, over the graft and fitted the incus into an "eye" fashioned on top of the stapes.

Fowler [24] described a technic in which a segment of the anterior crus was cut off close to the footplate of the stapes thus leaving a gap of bone at the site. The stapes footplate was then fractured, preferably behind the otosclerotic focus. The sounds were transmitted to the posterior crus of the footplate which was now again mobile. This resulted in good hearing. A good gain was achieved with partial mobilization of the footplate.

IN 1957 the attack on the fixed footplate increased in intensity. Narrow, sharp chisels, blunt chisels, needles of various thickness, and dental burrs were used. Schuknecht [25] wrote that the "injudicious use of hammer blows to a rigid stapedial footplate can create an acoustic impulse of sufficient intensity to injure the organ of Corti in the basal turn."

House [26] attacked the footplate directly when excessive pressure for mobilization seemed necessary or when the crurae were fractured. Pressures were applied on a dull needle along the footplate margins. When this failed he used a pneumatic hammer technic. A controlled pulsating pressure was applied. This could be varied in intensity and frequency. There was less danger of the hammer's dropping into the vestibule after direct footplate fracture. Then in 1957 Goodhill and Holcomb [27] reported on their technic of trans-incudal or trans-capitular

force. The term is self-explanatory and possibly was being used by most stapes surgeons. It can be used successfully in relatively early or mild ankylosis states.[27] If the otosclerosis invaded the anterior limb and anterior crus then they used Fowler's technic.[24] If only the footplate and ligament were involved, they resorted to the peri-basal use of a needle probe as advocated by Rosen.[20] In very severe ankylosis, Goodhill and Holcomb[27] used a chisel or hammer force.

In 1957 otologists reported varying degrees of success following mobilization of the stapes. Much of the statistical difference in the success of the surgery was due to different methods of classification of pathology and clinical findings. However, the number of successes acted as a spur to the otologist. New methods and innovations would be the key to increased hearing results.

Myerson[28] issued a further report on his experiences with trans-ossicular mobilization of the stapes in which he reported 58 per cent success in selected cases. The appeal of this technic lay in the fact that no incision and dissection were necessary for an approach into the middle ear. Muermann[29] tried to substitute a piece of Polystan® for the crura but was not successful. This was attempted in situations where both crurae had fractured. Pick[30] recommended the introduction of "contact" hearing tests, and the use of a skin graft to produce a columella effect when physiologic sound transmission cannot otherwise be recovered. In selected cases Pick was able to get a return of normal auditory acuity, or at least a return of hearing to a serviceable level in 40 to 50 per cent of the cases.

In 1957, Portmann and Claverie[31] attacked the solidly fixed footplate with a microdrill, aided by the operating microscope. The drill, the extremity of which is 0.2 millimeters thick, could turn from 8 to 10,000 revolutions per minute. A "stapedio-vestibular osteotomy" was then done, burring either the anterior part of the footplate or all round the edge of the footplate, depending on the amount of the pathology.

Shea[32] invaded the otosclerotic focus with a sharp pointed instrument or a drill, depending on the amount of sclerosis. The penetration was complete only when labryinthine fluid appeared. In more severe cases of fixation of the stapes Shea[32] fractured the crurae at the footplate. He then drilled a fenestra in the footplate. The fenestra was next covered by a vein graft (intima side out) and the remaining crus of the stapes was then shifted backward so that its end was resting on the vein graft over the center of the fenestra. If the crura could not be used then Shea[32] inserted a 90 polyethylene tubing, between the capitulum of the incus and the vein graft, after removing the head and arch of the stapes.

Postman and Claverie[33] did a stapedio-vestibular osteotomy and removal of the stapes, disarticulating the incus. A vein graft was then placed on the oval window and the stapes was replaced on the head of the stapes. The footplate was conserved whenever possible. This was referred to as the "interposition operation."

In 1957, Scheer[34] observed acceptable hearing improvement in 75 per cent to 80 per cent of the cases. This was a marked increase over his previous report of 33 per cent.[16] Scheer attributed his better results to his use of the trans-incudal technic described by Goodhill.[27] Scheer used three steps:

1. Pulsating pressure is applied by a curved pick into the end of the long process of the incus. This transmits pressure to the head of the stapes, pushing the footplate into the oval window.

2. If step one was unsuccessful, then a curved pick was placed with pulsating pressure on the lip of the posterior aspect of the head of the stapes. Pressure is directed toward the posterior crus. A back and forth rotary movement may also be needed.

3. This step is resorted to when the stapes has resisted mobilization. Using the Zeiss microscope, the sharp and blunt picks were used around the margins of the footplate or just behind the anterior crus when fixation is complete.

Kodman and Sperrazzo [35] analyzed 44 successful mobilizations done by Juers and Scheer. They concluded that there was no significant correlation between age and the degree of postoperative improvement in the patient. Bellucci [36] found immediate improvement in 35 of 100 cases by mobilizing the stapes with force applied to the neck. After one year, six had returned to the pre-operative level. When force was applied directly to the footplate there were 72 with immediate improvement. At the end of four months, 17 per cent had returned to the pre-operative level.

BETTER to analyze the results of stapes surgery, Bellucci [36] devised a surgical classification of otosclerosis:

CLASS 1. EARLY OTOSCLEROSIS

1. Good exposure and visualization of the footplate is possible.
2. No narrowing of the stapedio-vestibular joint and no otosclerosis visible.
3. The footplate is of a normal blue color, smooth and regular.
4. Palpation reveals fixation at one end of the footplate and motion at the other.

CLASS 2. MODERATELY ADVANCED OTOSCLEROSIS

1. Good exposure and visualization of footplate.
2. Definite narrowing of the stapedio-vestibular joint. A portion of the footplate, but neither crus is involved.
3. Normal blue color of footplate is present except near the otosclerotic focus where it is white.
4. Palpation reveals solid fixation at one end of the stapes and only slight motion at the other.

CLASS 3. ADVANCED OTOSCLEROSIS

1. Good exposure and visualization of the footplate is present.
3. Otosclerosis involves the stapedio-vestibular joint, one crus, and part of the footplate.
3. White bone near the otosclerotic lesion.
4. Solid fixation at most of the footplate; slight motion at the uninvolved end.

CLASS 4. UNFAVORABLE FOR MOBILIZATION

1. Poor exposure and visualization of the oval window.
2. Large otosclerotic lesions which replaced the footplate with white bone obliterating the stapedio-vestibular joint.
3. Extensive lesions originating from the margin at the promontory and involving both crura. Cases with blue footplate, but the crura are solidly fixed at the promintory edge.

Shambaugh,[37] in 1958, listed three factors responsible for the greater number of successful cases. *First,* the utilization of audiometric testing during the operation. *Second,* the routine use of the operating microscope. *Third,* the direct attack upon the footplate. This was made possible by the microscope.

In experiments on animals, Fernandez, Allen and Lindsay [38] concluded that the fenestra ovalis cannot restore the reference or normal cochlear responses once the transformer action of the middle ear mechanism has been altered.

Goodhill [39] laid down minimum requirements for mobilization surgery as follows:

1. An air bone gap of at least 25 decibels in the speech frequencies and the demonstration of a negative Rinne with the 500 and 1000 cycle tuning forks.
2. A bone conduction threshold not lower than 40 decibels in the speech frequencies.
3. A speech discrimination score with PB words not lower than 75 per cent.
4. Unilateral cases, if carefully confirmed by Weber lateralization, by quantitative masking and by Barany noise machine, providing that there is an expectation to reach the 30 decibel level, thus giving the patient the possibility of restoration of binaural hearing.
5. The poor ear should be done first.
6. No simultaneous bilateral surgery.
7. The second ear should be done at least four months later.

The first half of the year 1959 saw only a meager amount of literature published on stapes surgery. I call this the period of consolidation of new technics. Otologists needed time to digest the new ideas as those of Shea,[31] with his removal of the stapes, fenestra of the footplate, and the application of a vein

graft and polyethylene tubing. Time was also needed to perfect the handling of the microdrill, needles, pick, and so on. Then House,[40] in June 1959, removed the crurae and head of the stapes, thinned the oval window with a drill and fitted a number 90 polyethylene tubing, after the method of Shea.[31] After this, the thinned footplate was gently shattered by means of a chisel.

A short time later, House[41] reported that where bipolar fixation occurred he routinely removed the stapes crura and instituted the polyethylene strut.

In cases of the solid foot plate, House inserted a vein graft or Gelfoam® to cover the oval window after fenestrating with the diamond drill. This was followed by the placing of the polyethylene strut into position between the graft and the capitulum of the incus.

At approximately the same time, Scheer[42] reported his results on the use of the polyethylene strut. This strut was placed directly on the mobilized footplate. No vein graft or Gelfoam® had been tried yet by Scheer. This was done in 95 cases in which their crura had been unintentionally fractured in attempts to mobilize the whole stapes. Eighty-three of the 95 patients obtained improved hearing. The air-bone gap was closed in 29 cases. Forty-two came within 20 decibels of the bone-conduction level in the major speech frequencies. And 12 patients improved 10 to 15 decibels in these same frequencies.

Schuknecht and Oleksuik[43] removed the head, neck, and crurae of the stapes by means of a pick or needle. Then they mobilized the footplate. They used a stainless steel wire or tantalum as the prosthesis instead of the polyethylene tubing. The ring end was in contact with the footplate while the other end was hooked over the stapes.

In severe otosclerotic lesions they did a stapedectomy and soft tissue graft with the prosthesis. They used various grafts consisting of mucosa, adipose tissue, connective tissue, and vein. In later re-operation they found no connective tissue proliferation or fibrous bands in excess of that found in stapes mobilization procedures without prosthesis.

Since 1960 many otologists have resorted to a stapedectomy in more and more situations.

Rosen[44] reiterated that the stapedectomy should be done only after all other mobilization procedures have been exhaustively tried.

In May 1961, Bellucci[45] stated that he does not do a stapedectomy unless other procedures would not avail. He reported a "bypass" surgery of the stapes in which he removes the crura, head, and neck of the stapes and then inserts a polyethylene strut from the footplate onto the capitulum of the incus. This strut is just long enough to exert a slight tension on the footplate so that when the footplace is mobilized it is very slightly depressed. Bellucci[45] hopes that this depression will prevent re-ankylosis of the stapedio-vestibular joint. I have used this method in slightly under 50 cases with immediate improvement in hearing of 78 per cent. Enough time has not elapsed to prepare a study of regressions.

This paper would not be complete without this admonition from Fowler.[46] Although stated in 1957 in reference to stapes surgery, it still applies: "We must have concerted action, at once, on the histopathologic front. If we do not do something about our lack of knowledge, too many ears throughout the world will be nonsalvagable because of our present uninformed, and often blind, methods of attacking the stapes. We cannot advance in this micro-orthopedic surgery without the study, the knowledge, and the skill which comes from constant use of the long-focal length microscope in the operating room and the high-power microscope in the laboratory."

413 - 60th Street

A bibliographic listing of 46 citations appears in Dr. Boyers' reprints.

Henry J. Heimlich, M.D.

New Rochelle, N. Y.

Reconstruction of the Esophagus*

Persons with esophageal obstruction are miserable because of their inability to swallow. By means of an ingenious "reversed gastric tube" procedure, it may be possible to reconstruct the entire esophagus.

It is no longer necessary to subject the patient with benign obstruction of the esophagus to a gastrostomy or multiple dilatations. Five years experience using a reversed gastric tube to reconstruct the entire esophagus indicates that it is a safe and physiologic method. In addition, when a cancer of the esophagus can be resected, it is possible to construct a new esophagus by means of this operation.

TECHNIC

The abdomen is entered through a left subcostal incision. The tail of the pancreas is freed from the underlying tissue, and the splenic vessels are ligated in the hilus of the spleen, which is removed. Blood passing through the splenic vessels is now directed into the left gastroepiploic arteries, which supply the greater curvature of the stomach and must be preserved.

Using a Japanese stapling instrument, two parallel rows of staples are inserted into the stomach, 2 centimeters from the greater curvature and parallel to it. An incision is made between the rows of stapes and the staples are inverted with a continuous silk suture. The gastric tube is thereby formed. Then a cervical incision is made anterior and parallel to the left sternomastoid muscle. A subcutaneous tunnel is created in the avascular plane anterior to the incision in the neck. The gastric tube is drawn through the tunnel, accompanied by its vascular supply, the left gastroepiploic vessels. These blood vessels accompanying the gastric tube, can reach to the pharynx, owing to the fact that the freed tail of the pancreas extends to the costal margin and is accompanied by the splenic vessels.

The cervical esophagus is dissected free and transected two centimeters distal to the phar-

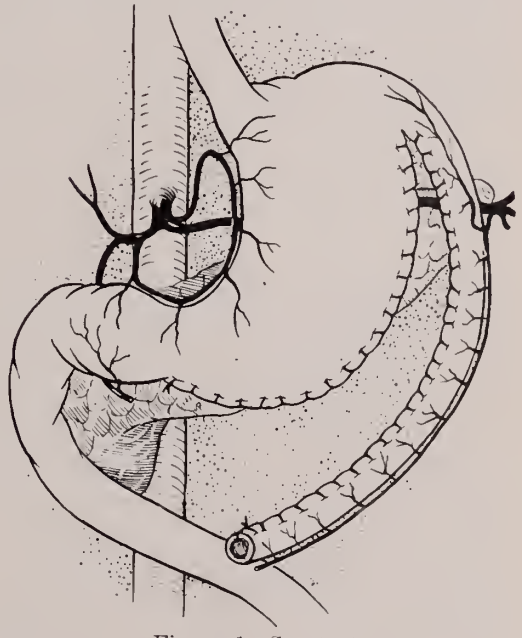


Figure 1: See text.

*This paper was presented in Atlantic City at the 196th Annual Meeting of The Medical Society of New Jersey, May 15, 1962. This work was supported by the Dysphagia Foundation, New Rochelle, N.Y.

ynx. The distal end of the esophagus is closed and allowed to retract into the thorax. The reversed gastric tube, wrapped with the gastrocolic omentum, is anastomosed to the proximal esophagus.

In two of the patients described below, the gastric tube was attached considerably higher than the cervical esophagus. In Case 3, the tube was anastomosed end-to-side to the hypopharynx above the cricopharyngeus and, in Case 4, it was anastomosed at the level of the pyriform fossa in the hypopharynx.

If the esophageal obstruction is due to a benign lesion or inoperable carcinoma, the nonfunctioning diseased esophagus is left *in situ* in the chest. When a resectable carcinoma is present, radioactive cobalt therapy is directed to the tumor. A right thoracotomy is then performed and the entire esophagus is resected.

CASE ONE

Carcinoma of the upper third of the thoracic esophagus: A 35-year old woman had a squamous cell carcinoma of the upper third of the esophagus. A reversed gastric tube was constructed for this patient at Montefiore Hospital. Two weeks later, right thoracotomy was performed and the entire esophagus was removed. The patient ate a regular diet until she died two years later from metastatic carcinoma.

CASE TWO

Lye stricture in the esophagus at the level of the aortic arch: A 45-year old female had been unable to swallow liquids or solids since drinking lye in a suicide attempt. Gastrostomy had been done at the time of injury, one and one-half years prior to her admission to Metropolitan Hospital. At that time, esophagram demonstrated an almost complete obstruction of the thoracic esophagus and a second constriction in the cervical esophagus. At operation done 20 months after swallowing the lye, a reversed gastric tube was constructed and anastomosed to the cervical esophagus above the highest stricture. Although the stomach was markedly thickened and somewhat fibrotic, there was no difficulty in creating a gastric tube of adequate length to reach to the neck.

The patient has continued to eat a regular diet without difficulty to the present time, four years after operation.



Figure 2: See text.

CASE THREE

Twenty-nine years of complete pharyngoesophageal obstruction from lye stricture: A 52-year old female was admitted to Montefiore Hospital. Twenty-nine years prior to admission, she had accidentally swallowed lye and was admitted to a hospital where an emergency Stamm gastrostomy was done. Although esophageal bougienage was performed several times at that hospital over a period of two years, the esophagus became completely obstructed.

At that time, the Stamm gastrostomy was not functioning satisfactorily and a second gastrostomy of the Janeway type was tried at a second hospital.

She subsequently married and had two children, both by cesarean section. She has been in good health except for lobar pneumonia at age 45 and repeated respiratory infections.

For 29 years she maintained her nutrition by chewing food and expectorating it into a funnel attached to a large gastrostomy tube. She was able to maintain excellent nutrition in this manner and, on admission, weighed 176 pounds. If, however, food reached the back of her throat she would choke and gag due to aspiration. Saliva pooled in the back of her throat causing her to expectorate at least once every hour. The patient's main reason for desiring an operation was to restore the function of swallowing. Her abnormal manner of eating made it impossible for her to eat with her family and friends. Esophagoscopy now showed complete stenosis due to stricture at the level of the cricopharyngeus.

Radiopaque dye by mouth showed a complete obstruction at the level of the cricopharyngeus.

A reversed gastric tube procedure was done. Although the stomach was markedly shrunken (due to the scarring from the lye and the two gastrostomy procedures) it was possible to bring the tube as



Figure 3: Case 2. Pre-operative barium swallow. Two partial lye strictures in the cervical esophagus, and an almost complete stenosis of the thoracic esophagus are evident.



Figure 4: Case 2. Postoperative barium swallow. The gastric tube is demonstrated and is seen to be anastomosed to the cervical esophagus, higher than the most proximal stricture.

high as the hypopharynx. Owing to the scarring in the cervical esophagus, it was necessary to do an end-to-side anastomosis between the gastric tube and the hypopharynx. The patient had a benign postoperative course and was permitted to swallow tea and Jello® two weeks after operation. The diet was gradually increased over the next two weeks at which time she was discharged from the hospital. She has remained well and asymptomatic to date and eats a regular diet in a normal manner.

CASE FOUR

Carcinoma of the cervical esophagus: Here there was a replacement of the esophagus after resection of larynx, part of the pharynx and the cervical esophagus. Prior to admission to Montefiore, a 62-year old woman had had the following surgical procedures performed in a hospital in another city: cervical esophagus was excised for postcricoid carcinoma, and a Teflon graft prosthesis was inserted to replace the cervical esophagus. Within a few weeks, the prosthesis became a source of infection and had to be removed. At this time, a laryngectomy was performed to prevent death by aspiration, a permanent tracheostomy was made, and a distal cervical esophagostomy created through which a Levin tube was inserted for feeding.

The patient was admitted to Montefiore Hospital one year after the procedures described above. Barium roentgenograms revealed complete pharyngeal obstruction. A reversed gastric tube procedure was done. Due to the high level of obstruction, it was necessary to anastomose this tube to the pyriform fossa in the hypopharynx. The patient was able to eat soft food thereafter, but could not swallow solids because the anastomosis had been made too narrow. She was readmitted to Montefiore four months after the operation. A reanastomosis was performed which was easily accomplished as the anastomosis lay directly beneath the subcutaneous tissue of the neck. She was discharged able to eat all foods. She continued to eat a normal diet until she died 8 months later due to recurrent carcinoma.

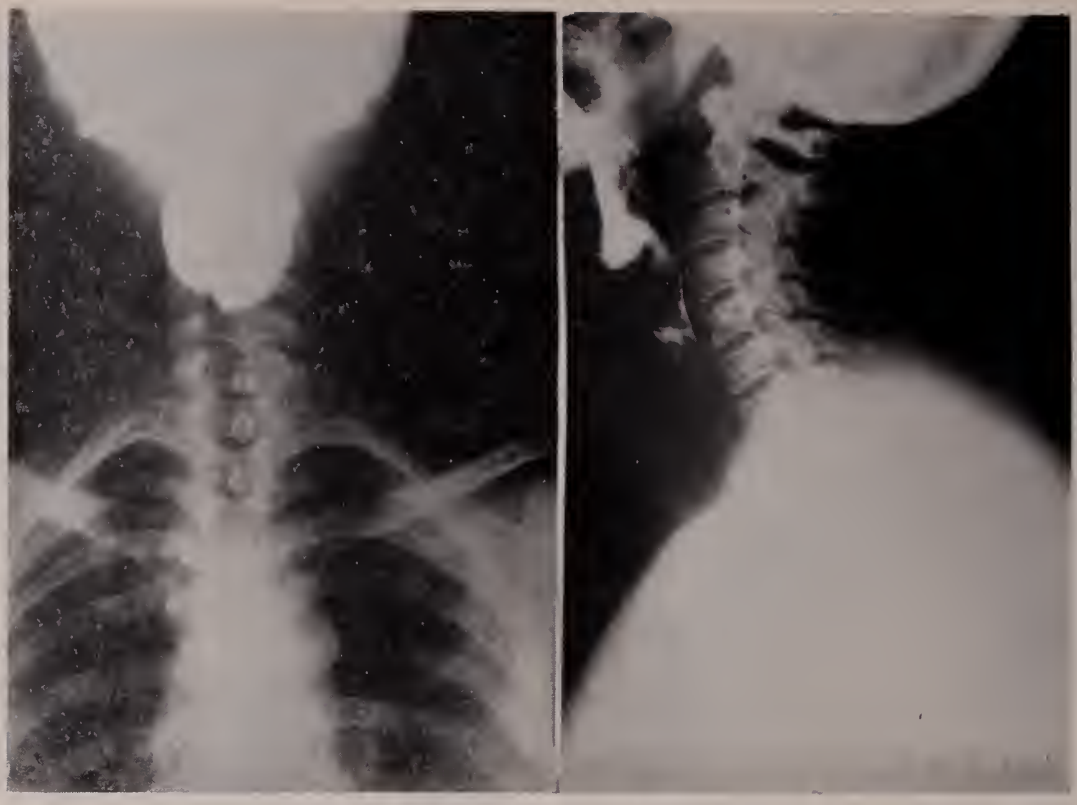


Figure 5a: Case 3. Preoperative barium swallow.
There is complete obstruction in the pharynx at the level of the cricopharyngeus.

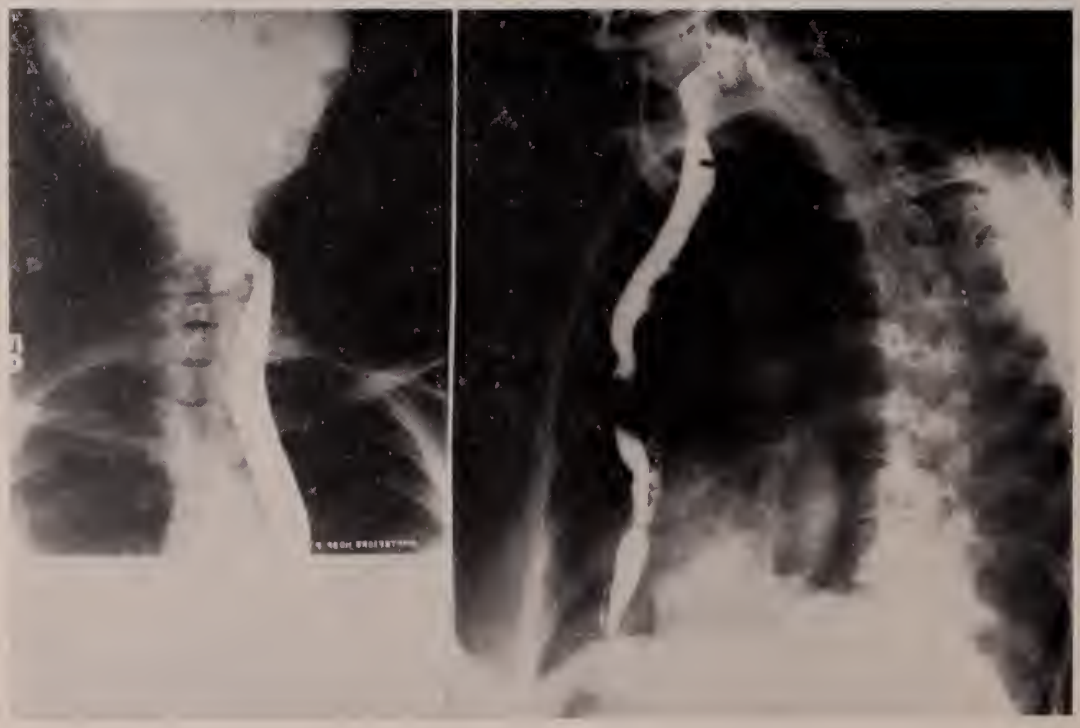


Figure 5b: Postoperative barium swallow.
The gastric tube is anastmosed end-to-side to the hypopharynx, proximal to the cricopharyngeus. The gap seen in the gastric tube is due to swallowed air.

SUMMARY AND CONCLUSIONS

We have used the reversed gastric tube operation to reconstruct the entire esophagus in 23 patients during the past five years. There have been 3 postoperative deaths. The operation has been successful in replacing the esophagus for the following conditions: (1) Carcinoma of the thoracic esophagus, (2) Carcinoma of the cervical esophagus, (3) Lye stricture of the esophagus, and (4) Peptic esophagitis with stricture.

This operation is a physiologic method of replacing the entire esophagus because: (a) It enables the patient to eat a regular diet. (b) No foreign material or intestinal organ (such as colon or jejunum) is interposed between the esophagus and the stomach. (c) Peptic esophagitis does not develop because the antrum of the stomach (which does not secrete acid) is brought upward and anastomosed to the esophagus, (d) Eighty per cent of the stomach remains in the abdomen and retains the normal storage function, and (e) The blood supply to the reversed gastric tube is excellent.

Quaker Ridge Road

Do Surgeons Work Hard?

Indirect calorimetry was used to determine the energy output of 11 physicians, four nurses, and one attendant during 22 surgical operations. A light portable respirometer was employed. Precautions were taken so that the operating field was not contaminated by any of the equipment.

For the most part, the energy expenditure was greater while the surgeon was scrubbing than while he was operating. Holding retractors required relatively little energy output.

An orderly who was busy changing a cast expended the greatest amount of energy per minute. In general, the energy expenditure for the surgical nurses was greater than in those participating in the operation. Most recreational activities have greater energy expenditure, for instance golf, riding and dancing.

Surgeons performing orthopedic operations expended energy at a rate which classified their activities as hard work.

—Levey, S., Drucker, W. and Czarnecki, N.: *Surgery,* 46:529 (1959).

Epilepsy and the Law

Do you ever see a patient subject to periodic attacks of impaired consciousness? If so, you will want to devote Wednesday afternoon, February 20, to a symposium on epilepsy and the law.

The meeting starts at 1:30 p.m. and will be held in the Gibraltar Building, Prudential Life Insurance Company, Bank Street at Washington Street in Newark. The meeting will adjourn promptly at 4:30 p.m.

Dr. Frederic Gibbs, the pioneer electroencephalographer, and a distinguished epileptologist, will open with a talk on the medical aspects of the problem. He will be followed by William Braun, of the New Jersey Bar, who will review the legal responsibilities of the physician in this area.

The third speaker, Ned Parsekian, is our State's Motor Vehicle Director. Mr. Parsekian will talk about the problem of driving licenses for epileptics. The patient's own responsibility in this area will then be reviewed by Mr. John A. Gleeson.

The meeting will conclude with a summation by Dean Roscoe L. Barrow.

This program is sponsored by the section on neurology and psychiatry of the New Jersey Academy of Medicine. Drs. Ira S. Ross and William Furst are chairman and secretary, respectively, of that section. There is no registration fee or admissions charge.

Evelyn Parker Ivey, M.D.
Morristown

Psychiatric and Alcoholic Patients in a General Hospital

A Report on Those Who Disturb Others

All doctors recognize nervous disorders and alcoholism as illnesses. Yet few admit such patients to general hospitals. Dr. Ivey here demonstrates the feasibility of treating psychiatric and alcoholic patients in a general hospital.

Since 1948 Morristown Memorial Hospital has been admitting selected psychiatric patients to its medical floors. In 1957 an Alcoholic Service was established [1] within the department of Internal Medicine to provide inpatient treatment for male and female alcoholics. In 1959, the Committee of Managers of this hospital, aware of the increasing admission of psychiatric and alcoholic patients and concerned for the restful atmosphere of this 250-bed hospital, requested the nurses to keep a notebook reporting all alcoholic and psychiatric patients known to be disturbing to others. The administrator gave the numerical report to the Managers each month. The Neuropsychiatric Section of the Medical Staff regularly reviewed the professional aspects of the reported patients and their care. Its Chairman recognized the need to relate statistics, the various features of the report, and discussions to gain perspective about the nature and extent of the problem.

COMMENT

This study encompassed those "Alcoholic and Psychiatric patients" reported as disturbing for the years 1960 and 1961. The discharge diagnoses supplied the information regarding the Services for tabulation. These included Alcoholic, Medical, Neurologic, Neurosurgical, Orthopedic, Psychiatric, Surgical, and Urologic Services. These findings were compared with the total admissions to each Service for the same period.

These same patients were then classified according to sex and age. Of the disturbed alcoholics, 66 per cent were men and 34 per cent were women. The disturbed patients on the Medical Service were also predominantly male, in the ratio 71 to 29. Males, indeed, had the higher proportion in all services except for Psychiatric. Here the reverse was true with 75 per cent female disturbed patients to 25 per cent male.

The most striking finding in the age distribution was that the fifth decade (ages 40 to 50) contained the greatest number of alcoholic and psychiatric patients. Of the 44 alcoholics reported during the two years, 48 per cent were between the ages of 40 and 50 while 45 per cent were in the two flanking decades (30 to 40 and 50 to 60 years). Half of the psychiatric patients reported were in the fifth decade while the other 50 per cent were evenly distributed among the fourth, sixth, seventh and eighth decades. In sharp contrast,

1. Parry, A. A.: Management of Alcoholism in a General Hospital. The Journal of The Medical Society of New Jersey, 56:725 (December, 1959).

the 24 reportees on the Medical Service skipped the fifth decade but showed a varying distribution among the other decades from the second through ninth.

Nurses had been instructed to report only those alcoholic and psychiatric patients who were *disturbing*. In spite of this instruction, a small number of Medical, Surgical, Orthopedic, and Urologic patients were included. Yet no Obstetric, Gynecologic, or Pediatric patients were reported.

Our figures show a two-thirds decline of disturbed alcoholic patients in the second year despite the increase in admissions of this category. The number of disturbed psychiatric patients remained the same, but since there were fewer admissions in 1961 the percentage rose slightly. Differences within the other Services were not large.

The only statistically significant difference in the percentage of disturbance within the two years occurred in the case of the alcoholic. Since alcoholic patients are alcoholics regardless of the year, it seems reasonable to hypothesize that the fewer patients reported as disturbing may reflect either increased understanding and ability of the Staff to care for the patients or more effective treatment, or both.

The Neuropsychiatric Staff's review of the patients revealed some enlightening facts. In some instances, those reported were disturbing only to hospital personnel. For example, a psychiatric patient who remained in a "quiet room" was regarded as disturbing because she refused to let any of her special nurses in her room. This lady was neither noisy nor troublesome in any way to the other patients. In another instance, an alcoholic patient walked out of the hospital without leave, causing consternation among the personnel. This concern became relieved on the patient's voluntary return several hours later. Conversely, other patients known to the Neuropsychiatric Staff as having been restless, noisy, combative, and prone to wander into the rooms of other patients were not listed.

Relatively few surgical and no obstetric, gynecologic, or pediatric patients were reported. This suggests that the disturbed patients on these Services might have stimulated compassion. As described in *Action for Mental Health*,[2] the public often shows different attitudes toward those whose illness has a mental manifestation contrasted with those whose symptoms are regarded as physical. Likewise the patients may show unique characteristics. The "physically-ill" patient for the most part is aware that something is wrong and is eager for help. The "mentally-ill" patient, on the other hand, may neither be aware of his need of help, nor receptive to it. The symptoms of his illness may trigger either compassion or resentment. The nature of his illness may evoke understanding, rejecting, or punitive attitudes. Thus, disturbed behavior developing after surgery, an acute infection, heart ailment, or other physiologic upheaval, may be regarded sympathetically as something over which the patient has no control.

One female Urologic patient illustrates some of these differences in attitudes. On the evening preceding surgery, she had a psychotic episode and became so noisy and disturbing that she was discharged at once. The urologist requested psychiatric assistance in enabling the patient to have her much needed surgery. Every attempt was made to understand and allay the factors which triggered the psychotic episode. Within a month, the patient was readmitted and had her operation. Thirty hours later, however, there was a brief episode of psychotic behavior in which she was noisy, moaning, groaning, and uttering blood-curdling screams. Though this episode was terminated promptly, it nevertheless had been disturbing to everyone in that wing of the hospital. This was not reported as disturbing even though it was as marked as the occurrence of the preceding month. That is, the disturbed behavior following surgery was not reported, whereas similar behavior prior to surgery in the preceding admission had been. This difference suggests the greater empathy, mentioned above, on the part of the nurses.

The alcoholic patient almost universally evokes resentment. Alcoholism has been re-

2. Final Report of the Joint Commission on Mental Illness and Health: *Action for Mental Health*. Basic Books, 1961, New York.

garded as sickness only recently and its acceptance as such remains limited. People often regard it as a moral infringement since they believe that the alcoholic certainly could resist that first drink.

Other factors which disturb patients are never tabulated and rarely are discussed within professional circles despite the prevalence of knowledge within the community. The chattering roommate is one who most interferes with rest in the general hospital. The talking of visitors to one patient while the roommate wishes silence may interfere with comfort and retard convalescence. A very sick or dying patient may be traumatic to a less sick roommate. The commotion involved in the medical care of the very ill is only one aspect. The effect on the emotional adjustment of the other patient may be marked though not apparent. The enhanced fear of death or other resulting psychologic reactions may promulgate illness and delay convalescence.

CONCLUSIONS

THESE findings reduce a major concern about a problem in patient management to the size of "a tempest in a teapot." The incidence of disturbance among alcoholic and psychiatric patients integrated within the general hospital does not appreciably increase the factors which interfere with rest. The special attention here directed to the disturbance is consistent with the pioneering admission of alcoholic and psychiatric patients to a hospital without special physical facilities. Further knowledge can help to allay residual rejecting, punitive attitudes among the public. There is some indication that if all the disturbing situations were reviewed quantitatively and qualitatively, those related to special types of patients would be minimal. The facts clearly reveal the feasibility of treating alcoholic and psychiatric patients within the general hospital. Further, the inclusion of a program for handling such patients may contribute to the relief of disturbing behavior throughout the hospital. A separate Neuropsychiatric Unit would provide additional advantages in intensive treatment to a variety of patients.

All patients, regardless of the nature of the illness, are especially vulnerable to emotional conflicts. Increased understanding of each patient's adjustment and to his reactions to his illness, and his sensitivity to hospital experiences represents one of the greatest challenges to medicine.

41 Elm Street

Can Dental Disorders be Psychosomatic?

Sometimes they can, says Dr. John H. Manhold, professor of oral pathology at Seton Hall. Certainly worry can precipitate or aggravate ulcers, gastric problems and other digestive complications. These same conditions may result in more cavities and other tooth problems. That's what Professor Manhold recently told the Academy of Psychosomatic Medicine in Minneapolis. He finds a greater incidence of tooth and gum disorders in situations where emotional disturbance is present.

Dr. Manhold said that psychologic factors are at play in tooth decay and periodontal disease. Among rats, he observed that one group subjected to stress had more cavities than another group not placed in stress situations. Emotionally disturbed people often grind their teeth, both while asleep and awake, resulting in damage to tooth sockets and supporting structures.

For most people, the professor's findings add up to a simple precept:

"Take life a little easier. It will pay in fewer visits to the dentist as well as the doctor."

Herman Beerman, M.D.

Philadelphia, Pa.

Eruptions and the New Drugs*

Adapted from an article in the October 1960 American Journal of the Medical Sciences (240:512) by Kirshbaum, Beerman and Stahl, this monograph brings up to date our knowledge of iatrogenic dermatitis.

To speak on common ground, we define a drug eruption as a cutaneous or mucocutaneous process incident to the administration of drugs, or their split products, which come in contact with the affected part by way of general circulation. The drugs responsible for these eruptions may be administered by ingestion, injection, inhalation, or inunction. Absorption may also occur from the skin; urinary bladder; conjunctiva; deep open wounds; the vaginal, anal, oral and nasal mucosae; the pulmonary system; mother's milk, and through the placenta. Reactions to local application of medicaments producing eczematous contact eruptions is excluded here.

The drug itself is not the whole cause of drug eruptions. Other factors predispose to their development. Among them are menses, menopause, pregnancy, other allergic processes, infections, functional states, organic disease—especially liver and cardiorenal—many skin diseases, physical factors, sunlight, heat, cold, weather, blood groups, vitamins, nutritional states, and the personal status of the patient.

While most of the eruptions due to drugs are mild, they do present the physician with a distinct nuisance. Any of the thousands of preparations and chemicals used as medicine may be responsible for drug eruptions. These eruptions are less frequent than those known to be produced by foods. Present sensitizing incidence is four to six per cent to such drugs as penicillin, sulfa preparations, streptomycin and many new drugs. Ten to 15 per cent of children receiving probenecid-penicillin tablets develop such reactions.

Drug eruptions were rare in surgical patients, 20 years ago, although atropine, morphine, barbiturates, arsenicals, bromides and iodides did cause occasional reactions. Today, almost no current drug is exempt from the possibility of producing skin eruptions. Almost any drug under appropriate circumstances may produce a variety of reactions. For the past few years, an average of more than one new pharmaceutical prescription product per day has been introduced. In the past decade, this has amounted to about 4,000 new pharmaceutical products; 10,000 since 1938.

Nearly everyone is exposed to drugs, defining that word in the broad sense. This includes vitamins, hormones, serums, vehicles, adjuvants, chemical substances used in diagnostic procedures, flavoring agents, dyes and coloring materials, disinfectants, preservatives, and antibiotics which may be found in foods (for example, penicillin in milk). Also, there may be cross-sensitization with non-drug chem-

*Read by invitation, May 15, 1962 at the Annual Meeting of The Medical Society of New Jersey.

icals which are immunologically and chemically related to substances used medicinally.

In addition to the greater drug exposure, the incidence of drug eruptions has risen because the same drug used both systemically and locally enhances sensitization; drugs used intermittently favor sensitization by re-exposure; and more and more potent drugs are being used for relatively minor ailments.

However, the significance of drug eruptions is not reflected in the incidence figures. Because these eruptions may resemble so many other cutaneous diseases, and because persistence in the administration of the particular drug involved might end in disaster, the diagnostic clinical features of the eruption produced by the various drugs must be clearly understood by the practitioner.

Cutaneous drug reactions are often associated with related changes in other organs. Thus: *hematopoietic system*: (blood dyscrasias; leukopenia, even to agranulocytosis, aplastic anemia; thrombocytopenia); *liver*: (toxic hepatitis, bile "inspissation" type, usually benign; or occasionally with parenchymal damage which may be extremely severe); *kidney*: (albuminuria, crystalluria; occasionally anuria due to tubule blockage; acute interstitial nephritis and lower nephron nephrosis); *respiratory tract*: (laryngeal edema; bronchial mucus plugs, and "drug asthma"; Loeffler's syndrome, and the pulmonary changes (alveolar rupture) in anaphylactic shock); *gastrointestinal tract*: (diarrhea, hemorrhage, gastritis, enterocolitis; other gastric and colonic disorders; moniliasis); *mucous membranes*: (stomatitis, gingivitis, gingival hypertrophy; conjunctivitis; vaginitis); *vascular systems*: (vasospasm; shock; periarteritis nodosa; thrombophlebitis; nodular vasculitis; serum sickness, which produces a variety of manifestations in divers tissues, including giant urticaria, angioneurotic edema, fever and arthritis); and the *central nervous system*.

Drug eruptions may present themselves on the skin in a variety of clinical patterns. *Often they will imitate common dermatoses in their appearance.* A partial list of such eruptions, produced by drugs includes: acneiform; furunculoid; erysipelas-like; eczematous (with erythema, papulation, vesiculation, fissuring, weeping, crusting, and scaling); erythema multiforme-like; erythema nodosum-like; and "fixed" eruptions (that is, fixed, circumscribed, erythematous, edematous or bullous, and polychromatic pigmented eruptions); lichenoid and lichen planus-like: pemphigoid, ulcerating and vegetating; purpuric, bullous; scaling; purely erythematous or scarlatiniform and morbilliform; dermatitis exfoliativa; urticaria and angioneurotic edema. Psoriasiform and hyperkeratotic lesions, granulomatous lesions, pruritus, hyperpigmentation (melanoderma), and lupus erythematosus-like pictures, have also been reported. Other cutaneous manifestations observed after treatment with certain medicaments are: alopecia, anhidrosis, cutaneous atrophy, glossitis, photosensitivity, stomatitis, seborrheic dermatitis-like eruptions; linea striae and hirsutism.

Non-drug dermatoses have a tendency to predispose patients to reactions to certain drugs, or exacerbation of the existing eruptions. For example, those who have acne, acneiform eruptions and furuncles are more susceptible to iodides, bromides, androgens, and other steroid hormones. Persons suffering with atopic dermatitis are more susceptible to salicylates. Individuals with dermatitis herpetiformis are more susceptible to iodides, bromides, and thyroid substances. Patients with hypertrichosis are more susceptible to androgenic substances.

PATHOGENESIS AND MECHANISM

THE way in which drugs produce eruptions is still unknown. Many mechanisms have been proposed. Among these are:

1. *Cumulative effect.* This factor plays a part in only certain drug reactions, notably arsenic.

2. *Pharmacologic-toxic mechanism.* This implies an effect that would develop in anyone who took the drug in adequate dosage for a sufficient length of time: such as argyria after the prolonged use of silver salts, or gangrene after large doses of ergot. It implies toxicity with cutaneous symptoms when drugs are used in larger doses

or for more prolonged periods than normally permissible.

3. *Enzymatic interference or competitive phenomenon.* Many drugs have been found to alter enzymatic activity or compete for components in enzyme systems.

4. *Photosensitization.* This implies the ability of certain agents to induce an alteration in the capacity of the skin to react to certain forms of actinic radiation. An inflammatory response to exposure to light on the skin may be induced by sulfonamides, porphyrins, antibiotics, especially dimethyl chlortetracycline, some tranquilizers (mainly phenothiazine and chlorpromazine derivatives), promethazine (phenergen) potent even on local application (cross sensitization between chlorpromazine and promathazine, and certain plants and oils. After recovery of thorazine photosensitivity exposure to sunlight even without the drug may cause flareup. In the management of this reaction it is necessary to avoid direct sunlight and other ultraviolet irradiation or the use of a sun screen.

5. *Intolerance or idiosyncrasy.* This is a purely individual phenomenon related to a person's inability to handle even small amounts of a drug; that is, doses which may be normal for the general population may, in relatively small amounts, cause abnormal response in certain individuals.

6. *Shwartzman phenomenon.* This may be responsible for certain hemorrhagic and necrotic cutaneous reactions.

7. *Jarisch-Herxheimer reaction.* The Jarish-Herxheimer effect is seen when a drug causes exacerbation of existing lesions or development of new ones, either because it too vigorously destroys the organisms for which it was used, or because it has such a wide bacterial spectrum that it kills many organisms besides the one for which it was administered.

8. *Ecologic imbalance.* Ecology is the study of the individual organism in relation to the total environment; this includes inter-species competition. The term ecologic imbalance refers to the disturbance of the normal inter-relationship of microorganisms. The concept of ecologic imbalance is now used to explain certain reactions seen after antibiotic therapy. Antibiotics may create this chaotic state by destroying certain organisms, thus making conditions more propitious for the growth of others.

9. *Biotrophic mechanism.* It has been postulated that bactericidal drugs may have a dual effect, necrotic and biotropic. The necrotropic effect is the lethal action of a drug on certain microorganisms. The biotropic effect implies that this same drug may be stimulating to other microorganisms.

10. *Allergic mechanisms.* Allergy is probably the basis of most lesions found in drug eruptions. There are two major forms of manifestations of allergic sensitization in human beings. These are: the immediate or urticarial type in which angioneurotic edema and even anaphylactoid reactions may occur (for example, seen after acute penicillin sensitivity). In these cases serum antibodies are often demonstrable, and desensitization is possible. However, many allergic reactions to drugs are of the delayed or tuberculin-type reaction classically manifested in the skin (such as the eczematous exfoliative dermatitis or arsphenamine) in which antibodies cannot be readily demonstrated in the circulation by any of the usual technics. Thus, there is no simple laboratory procedure by which the diagnosis can be made or the offending drug identified. The features of allergic drug eruptions include: the eruptions may be produced by minute amounts of a drug which may have previously been well-tolerated for years. The eruption may occur long after the last medication. It is likely to recur upon subsequent minute exposures to the offending drug or to a related drug (cross reaction). The clinical picture of the cutaneous response is entirely different from that produced by the pharmacologic or toxicologic action of the drug. Drugs with entirely different pharmacologic actions often produce identical eruptions. The same drug is often capable of producing radically different manifestations in different individuals, or in the same individual at different times. Many drug eruptions occur only in certain predisposed individuals and, regardless of the deliberate increase in dosage, will not appear in the majority of individuals. Marked specificity of drug sensitivity can often be demonstrated. Many manifestations produced by allergy to living micro-organisms or to natural allergens can be reproduced by drugs. They may exhibit incubation periods, spontaneous flare-ups and subsequent altered response to reexposure.

While drug eruptions are usually considered specific, there are enough variables in these findings to allow no generalizations on this subject. Skin tests are rarely of practical value in the search for eliciting agents of drug reactions. Only in exceptional instances, such as in true eczematous and occasionally in true urticarial drug eruptions, will the appropriate skin test prove valuable. In most drug reactions demonstration of the presence of a drug in the fluids or tissues of the patient does not constitute proof of the causal role of that drug. It proves only that the drug was encountered by the patient. In most drug reactions failure to demonstrate a drug in the fluids or tissues of the patient does not exonerate the drug as a possible causal agent. It proves only that the drug is not present in demonstrable quantity or form at the time of the examination.

DRUG ERUPTIONS AND L.E PHENOMENON

For some time the L.E. phenomenon has been considered by some to be rather nonspecific and can be found in a number of processes other than lupus erythematosus; for example, in multiple myeloma, arthritis, leukemia, hemolytic anemia, pernicious anemia, dermatitis herpetiformis, generalized moniliasis, and other cutaneous processes including sensitivity to certain drugs, penicillin, derivatives of hydantoin, sulfonamides, and, especially, Apresoline® (hydralazine). Since 1953, a number of instances of acute systemic lupus erythematosus-like or rheumatic and febrile syndromes from hydralazine hydrochloride (Apresoline®) have been reported. Comens and Schroeder concluded that the typical L.E cell may appear, though rarely, in the blood of asymptomatic patients receiving hydralazine. Comens was able to produce the syndrome experimentally. Hildreth and McCreary of the University of Pennsylvania observed that some of the hydralazine findings persist for years after administration of the medication has stopped.

ALLERGIC ANGIITIS

In recent years acute episodes of nonthrombocytopenic purpura, secondary to inflammation of the walls of small dermal blood vessels, have been given many names, such as: anaphylactoid purpura and allergic angiitis. This disease has become such an important problem that it is necessary to realize that a patient may give a history of sensitivity to various medicines such as sulfonamides, antibiotics, barbiturates or anticonvulsants; or to chemicals such as insecticides; or the patient may develop his eruption following the injection of serum or other protein.

The cutaneous lesions are symmetrical indicating a hematogenous factor in the spread of the injurious agent. No matter whatever eruption is present some form of purpura will manifest itself eventually in the skin as a result of this reaction. Bullous lesions or even cutaneous infarction with ulceration may develop.

FIXED DRUG ERUPTIONS

The term "fixed drug eruption" was introduced by Louis Brocq to indicate an eruption in which the cutaneous manifestation appeared as round or oval apparently edematous plaques varying in size from that of a small coin to that of a palm, recurring on various parts of the body and accompanied by an itching or burning sensation. The patches are erythematous and dusky at their onset and have well-defined borders. At times the lesions progress to form bullae. Desquamation or crusting after the bullous lesions appeared as the eruption faded, leaving pigmentation of variable shade and duration in the affected areas. A special feature of the eruption is its tendency to relapse with recurrence of the lesions in the same sites. The first drug from which this phenomenon was noted was antipyrine. Many drugs are now known to be responsible for fixed eruptions. The mechanism of the production of fixed drug eruptions remains unknown. Although there has been some work done on this matter, the exact process has not yet been elucidated. The patient apparently becomes sensitized after exposure for a period of time during which there may be no ill-effects. Although specific antibodies can rarely be demonstrated, it is believed that an allergic hypersensitivity is the basis for the fixed drug eruption.

From the foregoing statement of principles of drug eruptions, it is obvious that the basic mechanism or mechanisms of this phenomenon is still little understood. We propose here to mention some of the drugs in which there is current interest. Since the new drugs are legion, only a few of these preparations can be mentioned briefly.

ANTIBIOTIC DRUGS: PENICILLIN

According to Feinberg, penicillin has become the primary problem in drug allergy. This is denied by Flippin, who asserts that penicillin, after 20 years of use, is the most effective and least toxic of the antibiotics. The cutaneous manifestations include urticaria, exfoliative dermatitis, contact dermatitis, erythema nodosum, and erythema multiforme. Purpura and periarteritis and serum sickness also have been reported. In addition to the strictly medical application of penicillin, reactions have been observed from this drug from hidden sources such as milk and foods and poliomyelitis vaccine.

It was contended that penicillin given to cattle for mastitis is capable of producing immediate and delayed generalized allergic reactions in persons highly sensitive to this antibiotic, and that the comparatively rare reactions attributable to this source have probably gone unreported or unrecognized. Zimmerman observed penicillin urticaria (proved by penicillinase cures) from dairy products. However, the potentiality of ingested penicillin in milk to induce penicillin sensitivity in nonallergic individuals is suspected but not established Kern and Wimberley pointed out the widespread and sometimes injudicious use of penicillin has resulted in an increasing number of allergic reactions, some of which were quite severe, prolonged, incapacitating, and even fatal. Flippin described four types of allergic reactions to penicillin.

1. Immediate or anaphylactic (10 per cent end fatally or a typical asthma with urticaria develop).
2. Delayed serum sickness.
3. Delayed contact dermatitis.
4. The "id" reaction—flare-up of related fungal infection. Tuft and the Gregorys have indicated that the most satisfactory skin test for the detection of penicillin allergy is the intracutaneous injection of 0.02 milliliters of a concentration of penicillin of 10,000 units per milliliter.

Penicillinase has been used with variable success in the treatment of penicillin reactions. This enzyme-drug is not without its dangers.

Goldblatt and others have reported severe reactions to griseofulvin. There is no evidence to indicate the existence of a common antigenicity in griseofulvin and penicillin, or immunologic cross-sensitivity to these two antibiotics.

OTHER ANTIBIOTIC PREPARATIONS

In addition to penicillin, other antibiotic preparations including the sulfonamides have been responsible, and still are, for a number of cutaneous reactions.

Some of the reactions are difficult to assess with respect to the causative drugs since so many antibiotics are now used in combination. However, a partial listing of a few of the types of reactions reported will indicate their variety.

Pellagrous dermatitis.
Erythema multiforme.
Various eruptions from Novobiocin.
Urticaria. Most noteworthy among the reactions have been urticaria, generalized erythema, or maculopapular eruptions; and serum sickness occasionally.
Photosensitization (light sensitivity eruptions) due to tetracycline derivative (Declomycin®) (demethylchlortetracycline).
Tetracycline provocation in lupus erythematosus.
Fixed drug eruptions from Aureomycin.
Jaundice from Novobiocin.
Pruritus vulvae due to Aureomycin.
Black hairy tongue.
Dihydrostreptomycin, aminosalicylic acid, and isoniazid used in therapy of tuberculosis have caused reactions such as Loeffler's syndrome, as well as various pruritic lesions.

The fortunate aspect of some of these potentially serious reactions is that recently the steroids have proved of value in treatment.

SULFONAMIDES

The surprising number of eruptions still occurring from sulfonamide therapy is illustrated by sampling of recent reports of such.

Epidermolysis bullosa.
Erythema nodosum.
Fixed drug eruptions from sulfadiazine.
Other drug eruptions from sulfadiazine.

Photo-allergic dermatitis due to nadisan.

Various cutaneous reactions including urticaria, Stevens-Johnson syndrome, erythema multiforme, and fatal thrombocytopenic purpura from sulfamethoxypyridazine (Kynex®).

ANTIHISTAMINICS

ANTIHISTAMINICS are a minor factor in causation of drug eruptions. Patients exhibiting fixed drug eruptions, eczematoid dermatitis, and urticaria have been observed. All types of antihistaminics may cause reactions in sensitive individuals.

ANTIMALARIALS

THE antimalarials constitute an important therapeutic means in the management of lupus erythematosus. A number of interesting side-lights have recently appeared and may be of interest in individual case situations. Permanent anhidrosis, anhidrotic asthenia, and prolonged dermatitis have followed the development of atabrine dermatitis. Melanosis may be due to Camoquin®. Exfoliative dermatitis, decrease in human hair color, acute porphyria, as well as other types of porphyria have followed chloroquine. Jaundice may be simulated by the action of quinacrine (Atabrine®). Such difficulties in differential diagnosis which may arise when there are associated constitutional symptoms may lead to expensive hospitalization. The cutaneous reactions, however, are not the most serious of those arising from the antimalarials, since ocular changes and aplastic anemia have been recorded.

Quinine and quinidine have caused hematopoietic, as well as cutaneous problems, especially thrombocytopenic purpura.

ATARACTIC DRUGS

THE medical literature is replete with reports of the so-called tranquilizing drugs. This problem of cutaneous reactions is sufficiently large to merit a separate communication. It is possible at this time to indicate only certain features of the problem.

Cutaneous reactions have included desquamation of the skin over the fingers; contact dermatitis; stomatitis and proctitis; purpuric, maculopapular, vesicular, erythematosquamous eruptions; photosensitization (photo-allergy and photo-cross-sensitivity); hemorrhage from multiple sites associated with chlorpromazine-induced jaundice; nonthrombocytopenic purpura. In this connection agranulocytosis, jaundice and abnormal lactation may be mentioned. It is obvious from the reports that all the tranquilizers are capable of causing cutaneous reactions.

ANTI-EPILEPTICS

THE newer anti-epileptic drugs have been productive of constitutional reactions more than of cutaneous ones. The well-known Dilantin® hypertrophy of the gums and pigmentation from such drugs as Mesantoin® constitute the most common of the mucocutaneous manifestations. However, more recently visceral lupus erythematosus has been noted as a side effect of treatment with hydantoin derivatives.

HALOGENS

HALOGENS still constitute an important source of cutaneous reaction because of their widespread use, especially the iodides, in radiography. In addition, a certain number of patients with acne vulgaris may have their acne aggravated by the ingestion of certain vitamins with minerals, including some iodine preparations.

COUMADIN AND COUMARIN

THESE anticoagulant drugs have produced extensive dermatitis (Coumadin) and "purple toes" (Coumarin).

HEAVY METAL AND ARSENICAL DERMATOSES

With the passing of the organic arsenicals in the treatment of syphilis, the problem of arsenical cutaneous reactions is limited largely to the inorganic arsenicals. An occasional patient may develop organic arsenical reaction from such things as vaginal suppositories containing Acetarsol®. Sources of arsenic are many; and among them are asthma remedies and other medicinal sources, and the metallurgical industry.

Arsenic is probably able to produce cutaneous and pulmonary cancer. Bronchial carcinomas proved particularly malignant. In addition to the cutaneous lesions and carcinoma, toxic hepatitis or cirrhosis has been reported on several occasions as being due to Fowler's solution.

Use of bismuth and mercury compounds still produces some reactions.

STEROID THERAPY

Although steroids are notably useful in the treatment of drug eruptions they are not of themselves completely free of cutaneous ill effects. Kern's report on the use and abuse of steroid therapy, especially in allergic disorders, is a worthy guide for the employment of these drugs and an index of their potential noxious sequelae.

In 1950, Behrman and Goodman were among the first to report on the cutaneous complications in patients treated with ACTH. They observed hyperpigmentation, acneiform eruptions hirsutism, moon-face, striae atrophicae, delayed wound healing, and flattening of keloidal scars. Subsequently, dermatitis and ecymotic skin lesions were reported.

MISCELLANEOUS DRUGS PRODUCING REACTIONS

A number of medicaments used by the laity and medical profession are productive of eruptions, but do not necessarily fall into the previously discussed categories. A number of these will be mentioned briefly.

Antipyrine. Antipyrine was the first drug to have been demonstrated as responsible for fixed drug eruptions.

Oral antidiabetic preparations. An oral antidiabetic preparation, Carbutamide®, has been found to produce eruptions. This is a sulfonamide derivative having the property of reducing the blood sugar level. Carbutamide® has yielded its place to tolbutamid, known as Orinase®, which is considered a safer preparation but still yielding 1.1 per cent of dermatologic reactions. Chlorpropamide (Diabinese®), another of the oral hypoglycemic agents, has been reported as the causal agent of an erythema multiforme-like skin eruption.

Bromsulphalein. Bromsulphalein was responsible for a generalized severe coalescing morbilliform eruption.

Butazolidin or phenylbutazone has been responsible for a number of cutaneous and mucocutaneous lesions including exfoliative dermatitis.

Chloral hydrate. The commonest types of eruptions from chloral hydrate are: erythema, exanthemata, urticaria, eczematoid dermatitis, hemorrhagic lesions, erythema multiforme, fixed eruptions, ulcerative lesions and pyoderma-like lesions.

Colchicine derivatives. Alopecia totalis was noted after diacetylmethylcolchicine therapy of acute gout by a number of investigators. Vesicular dermatitis of the hands has also been seen in patients taking colchicine for gout.

Diamox® (acetazoleamiade). Diamox® has produced erythema multiforme and thrombocytopenic purpura.

Diuril® (chlorothiazide and hydrochlorothiazide). Erythematous, papular, and papulo-vesicular pruritic lesions on the upper and lower extremities, associated with edema of the hands and feet, have been seen after Diuril therapy. Thrombocytopenic purpura and photosensitivity eruptions have occurred after therapy with these preparations.

Endoxan. Endoxan, a cystostatic substance in nitrogen mustard, causes alopecia, especially in women.

Paraaminosalicylic Acid. Paraaminosalicylic acid has been responsible for the development of urticaria.

Phenindione. Phenindione, an anticoagulant preparation, has induced morbilliform lesions.

Poliomyelitis vaccine. As would be expected, cutaneous reactions from Salk poliomyelitis vaccine have appeared. The incidence of cutaneous reactions to this preparation is small. The cutaneous reactions may be urticaria, erythema multiforme, and others. It is possible that the penicillin in the vaccine may play a prominent role in the production of the lesions.

Temaril®. The new oral antipruritic. Temaril® has caused urticarial lesions and nonspecific cutaneous eruptions.

Tetraethylthiuram disulfide (*Antabuse®*). A fixed drug eruption has been reported from Antabuse®.

Thiouracyl derivatives. Hair loss and pigmentation due to thiouracyl derivatives have been seen.

Smallpox vaccine (*Vaccinia*). Leahy has mentioned cutaneous eruptions that may be caused by hypersensitivity to vaccinal proteins. These may develop 9 to 12 days after vaccination and include roseola, vaccinia, erythema multiforme, and urticaria.

DIAGNOSIS OF DRUG ERUPTIONS

THE diagnosis of drug eruptions frequently poses a challenge to the physician. Often one has an intuitive feeling that an eruption of local or widespread distribution is caused by a drug, though positive history of drug ingestion may be lacking. We have used the following procedures with varying degrees of benefit in the definitive diagnosis of eruptions due to medicaments.

1. *Suggestive clinical picture.*

2. *History.* The information that a patient is taking certain drugs may be of decided value in diagnosis if the following items are observed: initial exposure followed by a variable incubation period and then a sudden outbreak, increasing in severity and with a variety of constitutional symptoms, especially if the drug is continued, all point to the possibility of the eruption being of medicinal causation. The physician must not forget that the ingestion or administration of the medicament and the eruption may be coincidental.

3. *Course.* Improvement on withdrawal of the drug and flare-up after re-exposure. Readministration may be a hazardous procedure, even ending fatally. On the other hand, certain eruptions, (*e.g.*, bromide, iodide) may develop slowly and disappear long after the drug has been withdrawn. Similarly, the eruption may not appear until years later (arsenical keratoses and carcinoma). There may be sensivity to more than one drug and the eruption may not be due to the drug readministered.

4. *Diagnostic aids.* Cutaneous allergic tests are of little value. They may even induce sensitization or severe reactions. Results may be falsely positive or negative. Passive transfer procedures are also unreliable.

Chemical analysis of lesions, other tissues, and body fluids may yield positive results, thus identifying the presence of a particular remedial agent. The findings may, however, be coincidental. Spectroscopic studies have the same limitations.

Histopathology is certainly of value in bromoderma and iododerma which produce a typical pathologic response (iodide or bromide granuloma). In other cases there may be no clue in the pathologic picture of drug versus other causation of the eruption (*e.g.* lichen planus due to Atabrine® or arsenicals and liche planus of idiopathic causation).

Blood cell examinations are important, since blood dyscrasias often complicate a variety of drug eruptions.

TREATMENT

Withdrawing the offending drug usually effects cure of a drug eruption in a reasonably short time.

Supportive Treatment. In severe cases of Atabrine®, sulfonamide, and other eruptions, supportive treatment with liver extract, vitamin A, ascorbic acid and nicotinic acid may be of value.

BAL. As a by-product of successful intensive search for a substance that would serve as an antidote to the arsenical gases, it was found that 2,3-dimercaptopropanol (BAL, British anti-Lewisite) was also effective in the therapy of certain metal intoxications.

Antihistaminics. The antihistaminic drugs are of limited value against drug reactions of the skin and dermatitis may occur as a result of their administration. In spite of this, they should be given a thorough trial in drug eruptions.

Sodium Chloride. Sodium chloride is useful in the therapy of iodide or bromide eruptions.

Epinephrine. Epinephrine is on occasion still of use in anaphylaxis and certain urticarial eruptions (laryngeal edema, and so forth).

Ephedrine. Ephedrine has a limited usefulness in urticaria.

Steroids. These compounds are of considerable value in reducing the inflammatory element in dermatitis medicamentosa. They are especially useful in widespread eruptions. Cortisone or other steroid preparations are given with an initial high dose (*e.g.*, 300 milligrams cortisone per day). Hydrocortisone, ACTH, prednisone or prednisolone may be used in proportionate dosage. As the process improves, the dosage may be reduced fairly rapidly (*e.g.*, at a rate of 50 milligrams per day). Except in certain patients with exfoliative dermatitis, treatment need not be prolonged. Although corticotrophin or prednisone may themselves be responsible for eruptions (acneiform, dermatitis, etc.), they can be eliminated quickly by stopping treatment.

Local Treatment. Local treatment for drug eruptions follows the principles and procedures for therapy of the type of eruption a particular drug produces.

PREVENTION OF DERMATITIS MEDICAMENTOSA

PREVENTION is not always easy since drugs of a relatively high cutaneous sensitizing index are included in preparations in which their presence might not be suspected (*e.g.* phenolphthalein in cough syrup or effervescent salts) and such sensitizing medicaments are too often readily available on the open market. The best prophylactic for recurrent attacks is for the patient to avoid even minute quantities of the offending agent either for medicinal, testing or desensitizing purposes. Disregard of this caution may be fatal for the patient.

Drug houses have not been remiss in the distribution of warnings and recall of questionable drugs. Practitioners have often been less than up-to-date in their awareness of the facts. Since ignorance is no excuse before the law—or anywhere else—there is no alibi for not knowing what is known.

255 South Seventeenth Street

Clothing Guide for Handicapped Children

Designed to meet a long unfulfilled need of parents of crippled children is a new book: *Self-Help Clothing for Handicapped Children.* Written by professional staff members of the University of Connecticut and the Hartford Rehabilitation Center (and financed in part by Zeta Tau Alpha fraternity for women) the 84-page study brings together ideas and suggestions tested by parents and therapists in the United States, Canada, England and Sweden.

The text discusses the selection and adaptation of clothing for handicapped children. Included are 100 drawings for making outer clothing and underwear easier to put on and take off.

Co-authors of "Self-Help Clothing for Handicapped Children" are Neva R. Waggoner, M.A., coordinator of research on homemaker rehabilitation at the University of Connecticut, Eleanor Boettke, M.S., assistant professor from the school's Department of Textiles who made the drawings, and Clari Bare, OTR, supervisor of occupational therapy at the Hartford Rehabilitation Center.

Many suggestions are here given to parents and professional workers concerned with the difficulties crippled children must face in learning to dress themselves. Some come from a two-year study by Miss Boettke on "Work Simplification in the Area of Child Care for Physically Handicapped Women," a research and demonstration project sponsored by the Federal Office of Vocational Rehabilitation. The Connecticut Society for Crippled Children and Adults also collaborated in the study.

Other valuable data was secured from parents across the nation who responded to a questionnaire on clothing problems and from interviews with groups of handicapped young people who shared their ideas and feelings about clothing preferences.

Copies of *Self-Help Clothing for Handicapped Children* may be ordered from the National Society for Crippled Children and Adults, 2023 West Ogden Ave., Chicago 12, Ill., at 50 cents each.

Edwin J. Kroeker, M.D

David P. Boyd, M.D.

Boston, Mass.

Henry J. Schwarz, Jr., M.D

North Bergen

Kartagener's Syndrome*

Case Report and Review of the Literature

Presented here is an example of a rare, and—in this case—successfully handled instance of associated sinusitus, bronchiectasis and situs inversus

The triad of situs inversus viscerum, bronchiectasis and sinusitis was first reported by Siewert [1] in 1904. In 1933, Kartagener [2] reported four additional cases and became interested in this condition as a possible clue [3] to a congenital factor in the etiology of bronchiectasis.[4] An increase in the familial incidence of Kartagener's syndrome has been reported.[5,6,7,8] Recently, it was suggested [9] that there may be an increase of mucoviscidosis in patients with this condition. In all patients who have a history of bronchiectasis since early childhood, the diagnosis of mucoviscidosis and agammaglobulinemia must be entertained. Our case was another example of the familial incidence of Kartagener's syndrome in which no evidence of agammaglobulinemia or mucoviscidosis was found.

A 20-year old aircraft technician came to the Lahey Clinic on September 7, 1961, because of cough and sputum "all his life." The sputum was more copious on arising, was usually worse in the summer, and totaled two to three cups per day. It was greenish-yellow and foul. The patient considered himself a social outcast because of it. There were no known allergies and no history of wheezing, dyspnea or hemoptysis. From 1957 to 1959 he took chlortetracycline irregularly twice daily, with some improvement in his symptoms. He had never smoked. Tonsillectomy and adenoidectomy were done in 1947 without complications. The patient was the only surviving sibling of a family of three. One sister had died at the age of two of cyanotic congenital heart disease; another sister who had known dextrocardia died at the age of eight after an operation for bronchiectasis. The mother had died at the age of 48 of cancer of the breast. The father was living and well.

When we first saw him, he weighed 155 pounds, and his height was 5 feet 8 inches (3 inches shorter than his father). Blood pressure was 130/80; pulse, 76 and regular; temperature, 98 and respirations 16. Mild acne was noted on the face and neck. The sinuses transilluminated equally but poorly, and no polyps were seen. The lungs were hyperresonant with expiratory rhonchi bilaterally. The apex beat of the heart was heard in the fifth intercostal space, midclavicular line on the right. The remainder of the physical examination did not reveal abnormality, although it was noted that the right testis was lower than the left.

Laboratory studies, except for an increase in the gamma globulin fraction of the serum proteins, gave negative results, as did urinalysis. Blood tests included a hemoglobin of 12.4 Grams; hematocrit, 42 per cent; white count, 8100, with 61 per cent neutrophils, 2 per cent band forms, 25 per cent

*This work is from the Lahey Clinic.

lymphocytes, 8 per cent monocytes, and 4 per cent eosinophils. The sedimentation rate was 53 per hour; the blood Hinton test gave negative results; fasting blood sugar value was 82, and blood urea nitrogen, 13. Total serum proteins were 7.7 Grams, were 3.3 albumin and 4.4 globulin. The electrophoresis of serum proteins showed an increase of the gamma globulin fraction, and the zinc turbidity was 9 Kunkel units.

The result of a purified protein derivative, first strength skin test was negative. The Shwachman agar plate sweat test [10] to determine the amount of sodium chloride excreted in the palmar sweat gave negative results, indicating no evidence of mucoviscidosis. This was confirmed by quantitative study of the sweat excretion which showed an extremely low sodium chloride content.

Roentgenogram of the chest and bronchograms (see figures) revealed bilateral basal bronchiectasis with dextrocardia and partial collapse of both lower lobes. The gastric air bubble was seen beneath the right diaphragm. Roentgenograms of the sinuses were interpreted as showing an extensive, thickened membrane involving the frontal, ethmoid and maxillary sinuses.

On bronchoscopy, profuse mucopurulent secretions exuded from both major bronchi, which on culture, grew pneumococcus and Staphylococcus aureus coagulase positive which were sensitive to all tested antibiotics. Bronchography was done under general anesthesia as local anesthetics were diluted and washed out by the copious bronchial secretions.

Pre-operatively, postural drainage was instituted and Declomycin,† 150 milligrams, and buccal varidase were given every four hours. On the seventh hospital day a right lower lobectomy and resection of the lingula were done. A course of penicillin and streptomycin was started on the operative day and continued for one week. He was discharged from the hospital in good condition on the eleventh postoperative day. Three weeks later, he was raising only half a cup of slightly yellowish sputum. He returned to work the first of December, 1961. He was advised to take antibiotics at the first sign of a chest cold and to return in six months for evaluation relative to further resectional surgery on the left side.

Situs inversus viscerum has been recognized from antiquity. Among the ancients, Aristole is said to have noticed transposed organs in animals. Fabricus at Padua described a case of reversed liver and spleen in a human being. It was not until the early 19th century that the condition was first diagnosed clinically. By the latter part of the century such a diagnosis could be confirmed with accuracy by the newly discovered roentgen rays. Over 1000 cases have now been recorded, and it has been estimated [12] to occur in one in approximately 1400 of the general population. Situs inversus viscerum is not incompatible with normal health, however; Elisha Bartlett, a distinguished physician of his day, lived a normal life span with complete transposition of the viscera.

The condition itself may be complete or partial, may be limited to the abdominal or thoracic organs alone, and is often associated with numerous congenital abnormalities. In Kartagener's syndrome, as in our case, it is associated with bronchiectasis and sinusitis. Some cases described in the literature [13] have been of dextrocardia without complete situs inversus [14] and these are included as valid instances of the syndrome.

The literature up to 1950 is well reviewed by Bergstrom, Cook, Scannell and Berenberg.[8] They collected 80 cases including two of their own in a family in which two additional siblings suffered from bronchiectasis and sinusitis without dextrocardia, and the father from sinusitis only. Recent studies [14] distinguish the full Kartagener's triad, of which 132 have been reported to date, from the association of bronchiectasis and dextrocardia,[15] instances of which now total 228. The age at the time of diagnosis varies [17] from 5 to 69 years.

The bronchiectasis of Kartagener's syndrome is indistinguishable pathologically from the acquired tubular variety. It is more common in dextrocardia or complete visceral transposition, however, than in a control population. Olsen [14] reviewed 85 cases of dextrocardia and found 14 (16 per cent) to have bronchiectasis, as contrasted with an incidence of less than 0.5 per cent among all patients at the Mayo Clinic. His study and that by Adams and Churchill [18] lend support to the theory that the bronchiectasis in Kartagener's syndrome is of congenital origin. The theory is further supported by many cases in the literature in which the triad occurs in members of the same family.

Kartagener [4] also studied the possible relationship of sinusitis to bronchiectasis. Eighty-six patients with the acquired form of bron-

†Declomycin is Lederle's trade name for demethyl chlortetracycline.



a, Posteroanterior roentgenogram of the chest. Note the infiltration and partial atelectasis of both lower lobes while the upper lobes are remarkably clear. *b*, Posteroanterior roentgenogram of the chest after the instillation of aqueous Dionosil® into both main stem bronchi. Note the marked dilatation of the right lower lobe bronchi (anatomical left lower lobe and lingula). The left lower lobe is incompletely delineated while the upper lobes appear normal.

chiectasis had routine roentgenograms of the sinuses. Abnormal sinuses were present in 55 per cent, being either very small (35 per cent) or absent (20 per cent). In 100 normal control subjects, similar roentgenograms showed small sinuses in 18 per cent and absence of sinuses in 4 per cent, with a total incidence of abnormalities of 22 per cent. He reasoned[4] that bronchiectasis might be acquired secondarily to the sinusitis (aspiration of infected secretion) or the sinuses could become secondarily infected from bronchial secretions. The condition could also arise from a common exogenous factor, such as measles or influenza, which might affect both sinuses and bronchi. Because of the high incidence roentgenographically of abnormal sinuses of congenital origin in patients with acquired bronchiectasis, he thought that a common endogenous or congenital defect might be present in some persons, predisposing them to bronchiectasis and sinusitis.

It may well be that patients with Kartagener's syndrome are not born with bronchiectasis but only with the predisposition to it. Certainly, as in our case, partial atelectasis of the lower lobes[7] is common in this condition. No cases[16] of Kartagener's syndrome have been reported in stillbirths or neonatal deaths. This would seem important only in that children with dextrocardia should be observed closely so that prophylaxis or prompt treatment can be given for pulmonary infection.

Since childhood bronchiectasis may be present in conjunction with fibrocystic disease of the pancreas without symptoms of the pancreatic disease, it has been suggested[9] that Kartagener's syndrome may actually be fibrocystic disease of the pancreas occurring in patients with situs inversus viscerum. This interesting approach has been denied[19] in another case report. In our case, fibrocystic disease of the pancreas was ruled out. In all cases of documented childhood bronchiectasis

(including those of dextrocardia) *concomitant fibrocystic disease of the pancreas as well as agammaglobulinemia must be excluded* so that the proper treatment may be instituted. The approach to the treatment of bronchiectasis in Kartagener's syndrome must be similar to that of the more common form of acquired bronchiectasis.

8534 Hudson Boulevard (Dr. Schwarz)

Addendum: Since this article was submitted, the patient has had a lower lobectomy on the opposite side and has since then been symptom-free.

BIBLIOGRAPHY

1. Siewert, A. K.: Berl. Klin. Wchnschr., 41:139 (Feb.) 1904.
2. Kartagener, M.: Beitr. z. Klin. d. Tuberk., 83:489 (1933).
3. Kartagener, M.: Beitr. z. Klin. d. Tuberk., 84:73 (1933).
4. Kartagener, M. and Ulrich, K.: Beitr. z. Klin. d. Tuberk., 86:349 (1935).
5. Safian, L. S. and Mandeville, F. B.: Journal of the Florida M. A., 45:1143 (April) 1959.
6. Kartagener, M. and Horlacher, A.: Beitr. z. Klin. d. Tuberk., 87:331 (1935).
7. Knox, G., Murray, S. and Strang, L.: Annals of Human Genetics, 24:137 (May) 1960.
8. Bergstrom, W. H., Cook, C. D., Scannell, J. G. and Berenberg, W.: *Pediatrics*, 6:573 (Oct.) 1950.
9. Brown, N. M. and Smith, A. N.: British Medical Journal, 2:725 (Oct. 17) 1959.
10. Shwachman, H. and Gahm, N.: New England J. Med., 255:999 (Nov. 22) 1956.
11. Wood, G. O. and Blalock, A.: Archives of Surgery, 40:885 (May) 1940.
12. Lewald, L. T.: Journal of the American Medical Association, 84:261 (Jan. 24) 1925.
13. Dickey, L. B.: Diseases of the Chest, 23:657 (June) 1953.
14. Olsen, A. M.: Collected Papers of the Mayo Clinic and the Mayo Foundation, 34:764 (1942).
15. Eule, H.: Z. Tuberk., 114:189 (1960).
16. Nyiredy, G. and Ferenczy, S.: Beitr. z. Klin. d. Tuberk., 120:233 (1959).
17. Gude, H. E. and Hull, J. E.: J.A.M.A. 171:1825 (Nov. 28) 1959.
18. Adams, R. and Churchill, E. D.: Journal of Thoracic Surg., 7:206 (Dec.) 1937.
19. DeNiord, R. N.: Virginia Med. Monthly, 88:99 (Feb.) 1961.

Hair Spray Can be Dangerous

Ever hear of *thesaurismosis* or *thesaurosis?* It comes from the same root as "thesaurus" (treasury) and refers to the morbid effect of the storing in the body of accumulating foreign substances. According to Bergman and his co-workers (*New England Journal of Medicine*, 266:750, April, 1962) thesaurosis may result from continued daily use of hair spray.

In susceptible persons, inhalation of the spray can lead to storage of unusual amounts of foreign substance in body cells. Resins and similar compounds, common ingredients of hair sprays, cannot be metabolized by the body, the investigators said. Bergmann and associates reported on 12 new cases, including three fatalities, due to the spray. Three cases previously had been reported in the medical literature.

Among the symptoms in these patients were cough, extreme fatigue, weakness, dermatitis, respiratory infections and, in the three women who died (aged 22, 35, and 45), severe respiratory symptoms and lung lesions. All had applied hair spray daily for several years. X-rays of the chest in six patients "showed bilateral infiltrates of greater or less severity," the authors said. In almost all cases "discontinuance of hair-spray exposure has resulted in a fairly prompt regression of the lesion."

In a hairdresser, exposure to the spray continued following diagnosis "and the lesion remained essentially unchanged over a period of ten months," they added. Both significant inhalation and high susceptibility appear to be necessary to produce the lung lesions. Otherwise, the authors said, "it would hardly be possible for so many women to have used hair sprays for such long periods without many more cases of thesaurosis coming to light."

Richard I. Nevin

Trenton

Our Fading Freedom*

In inspiring terms, our Executive Officer here spotlights freedom as the one vitamin necessary to the healthy doctor-patient relationship.

Freedom is the absence of compulsion or coercion. It is the state of the individual which enables him to determine his actions and his attitudes. It is inseparable from responsibility, since he who makes the choice on his own authority and by his own power is responsible for what results. Conversely, he who is not free to choose is not responsible or accountable for the effects or consequences which follow. There can be no diminution of responsibility without a proportionate diminution of freedom.

Freedom is important to us in two ways . . . as men and as Americans.

It is important to us as men because freedom is natural to man. It flows from his rational nature, whose highest faculties of intellect and free will enable him to know the truth and goodness of the alternatives of action open to him, and, in the light of that knowledge, to make his choice. If man is not thus free—as we have already seen—he cannot be held accountable—either to himself, to society, or to God—for the effects in the production of which he shares.

If such freedom and accountability are denied to man as a rational person, then there is no basis in justice for the sanctions of law in the preservation of order, and the resultant state of society is anarchy and chaos. In the absence of laws based upon justice and rooted in freedom, the only remaining means of control is through the imposition of the will of the strong upon the will of the weak, and tyranny results.

Man as an individual is essentially dependent upon his freedom and responsibility if he is to enjoy the right to pursue his personal happiness. If happiness is the satisfaction of rational desire, only that person can hope to attain happiness who by the sovereignty of his own judgment determines, and by the exercise of his free strength achieves, the goals of his own desiring.

The sense of success in a man is proportional to his sense of having thus applied himself and having thus attained. The zest of his living consists in his stimulating awareness that to enjoy the chance of succeeding he must run the risk of failing. His triumph is the greater by this very fact, and his success the sweeter. The only true bitterness of failure, on the other hand, inheres in a man's consciousness that either he has freely chosen the wrong goals, or he has not measured up to the character and constancy of the efforts necessary to succeed. A bad result does not brand a man a failure; only personal inadequacy does.

Take from a man his personal freedom and responsibility and you deny him access to hap-

*Presented by Richard I. Nevin, Executive Officer ot The Medical Society of New Jersey, December 8, 1962, before the New Jersey Chapter of the American College of Surgeons.

piness—which is the principal hunger of his soul. Take from a man his personal freedom and responsibility and you empty his life of challenge or purpose, deny him the means to make himself master of his fate, condemn him in his day-by-day existence to a condition of insupportable futility, and make his life an oppressive burden to be dully borne instead of a splendid opportunity to build his strength and to use it to prove his worth.

That is why, in all ages, men and women bereft of freedom and reduced to servitude and slavery instead, have found, and will ever find, life no longer worth living. That is why in the hearts of all men and women who know the worth and necessity of personal freedom, there will always re-echo Patrick Henry's perfervid and meaningful cry "Give me liberty or give me death!"

Freedom is important to us as Americans because freedom is the foundation upon which our nation was built. Of all the nations that have ever existed, the United States of America alone from its earliest conception has been identified with and dedicated to the preservation of personal liberty.

Joseph Rodman Drake—in his poem—"The American Flag"—gives imaginative expression to our country's identification with freedom. He says . . .

When freedom from her mountain height
Unfurled her standard to the air,
She tore the azure robe of night
And set the stars of glory there.
She mingled with her gorgeous dyes
The milky baldric of the skies,
And striped its pure, celestial white
With streakings of the morning light.
Then, from his mansion in the sun
She called her eagle-bearer down,
And gave into his mighty hand
The symbol of her chosen land!

The poet indicates that Freedom chose us. The historical fact is otherwise. We chose freedom . . . and, God willing, we always will. For freedom is the source and fount of our country's greatness!

Our government was fashioned, our basic laws adopted, and our legal processes all designed to exalt, preserve, and protect the rights and the dignity of the individual American citizen. As a people we have ever vigorously resisted any movements or practices which would usurp or impair the freedom or basic rights or principles of our citizens or of our country. In this spirit, we engaged in "a great civil war." In this spirit, we have entered upon and prosecuted every war since. In this spirit, we are ready to engage in war today, or at any time in the future, with any and all powers that would threaten us from without.

In the past generation, however, we have as a people acquiesced in successive legislative measures, proposed to us as necessary or desirable for the furtherance of the general good, but in effect restrictive and destructive of our freedom, responsibility, independence, and self-reliance as individual citizens.

IT HAS always been acknowledged and accepted that it is the function of government to do for its citizens only that which they cannot do for themselves. To this end, the right of government to call upon its citizens to provide for the common defense—and for other acknowledged and necessary functions—by contributing their services and paying duly levied taxes has always been recognized.

But more and more, our government of late has enlarged the scope of its function and control by imposing increasing taxes of all kinds for the avowedly altruistic purpose of furthering the welfare of the people.

In consequence, we have come to the point where the burden of taxes has grown so great, and the gathering of taxes so inexorably important, that many of our citizens are left without sufficient of their own earnings to provide for their own needs and the needs of their families. Our citizens are increasingly restricted, in the management of their own lives and of their own business and professional operations, to the lines and limits set by our government.

The government is directing and controlling the lives of its citizens, where once the citizens directed and controlled the operations of

their government. Our freedom is progressively fading, but not under open attack or by overt ursurpation, but rather by our capitulation to the seductive argument that it is all being done for our good, that legislators and social planners are better able to plan and provide for our individual and group needs than we are ourselves.

Thus we are progressively surrendering our freedom, to acquire instead a promised and undependable security. We are in grave danger of discovering too late that we are neither free nor secure, neither independent nor self-reliant, without the strength or the spirit to resist the debilitating and deadly pressures that are reducing us to the status of wards and servants of an all-powerful state.

If these changes were productive of improvement in our social or economic situations as individual citizens, or if they increased our strength and power as a great nation, there would be good grounds for our approving them, even at the cost of the loss of some personal liberty. But the greater part of our citizens are either indebted to government for their day-by-day sustenance and support, or they are in debt to government for taxes so heavy that they find them almost impossible to pay.

Government, on the other hand, is constantly operating under a system of deficit financing, our gold reserves are dangerously depleted, and our public debts are of such mountainous and ever-increasing proportions as to threaten our economic collapse.

It becomes increasingly apparent that our country can be the land of the free only so long as it continues to be the home of the brave. The home of men and women brave enough and honest enough to realize that—all temptations to pleasing self-deception thrust side—we, the citizens, are the true strength of our country, and that we, as free men, must work to develop our individual strengths and abilities to the full, we must provide for ourselves and for our families by our own diligent efforts, and we must exercise our individual rights and do our individual duties as best we can, and always with enlightened regard for the rights and duties of our fellow citizens.

We must as a people reclaim and recapture our freedom, our dignity, our independence, our self-reliance, our honest ambition, and our eager industry, in order that we may meet the challenge of life and prove ourselves men, by overcoming and not by being overcome, by giving to our country and not by taking from it. This is our need and our country's need today. Not to face up to it and to meet it, is to betray both our nature as men and our privileged status as citizens of our beloved country.

As educated and able men, respected leaders in your profession and in your communities, your obligations as men and as citizens are the greater. It is not merely the freedom of the practitioners of medicine that is being threatened by the unsound and occasionally sinister legislative programs that are being urged upon us. Rather it is the freedom and independence of every American citizen, and the freedom and strength of our country that are at stake.

No country can be strong whose citizens—like perennial children—hang on it in growing numbers and with ever-increasing weight. In time, the country, thus burdened, will be dragged down by the sheer dependence of its people upon it.

Only that country will be strong whose citizens are strong, dedicated, and vitally productive, and who—from the abundance and exuberance of their strength and power—fortify their country against every adversity or vicissitude.

Let it be the purpose of each of us to spend himself in the effort to make our country strong in this way. Let us demand—and encourage our fellow citizens to demand—our rightful freedom as men and Americans. Then let us use that freedom well, giving of our best and our utmost to rekindle the pristine spirit of our country and insure it of its proper status as the best, strongest, and greatest country in the world.

The protagonists of the welfare state are indefatigably zeaous for their ends. Already the doors of opportunity are automatically closed to men and women who have reached the arbitrary age at which, according to the planners, for their own good they should retire. In consequence these men and women are, with pharisaical justification, denied the right to work and live as they choose, but must instead accept a status of miserable dependence. Their reward is the inadequate recompense of a meager social security monthly payment, and even that will be denied them if through gainful employment they dare to improve their own or their families' lot beyond the niggardly minimal limits set.

These hapless men and women—American citizens, endowed by their Creator with the "unalienable rights of life, liberty, and the pursuit of happiness"—have been discriminated against and—summarily bereft of their fundamental rights—some of them have been reduced to dependence and marginal destitution. But—as in the case of Petruchio when with calculated cruelty he strove to tame his shrew —"all is done in loving" of them.

It is our duty, in the interest of justice and humanity, to bend our efforts to liberate these men and women from their purgatorial plight, setting free, without handicap, those who wish to provide for themselves and to build their own security. At the same time we should seek to retain, and make available, adequate assistance for those who no longer have the strength or spirit to carry on for themselves. This is a program that will simultaneously rehabilitate both citizens and country.

Now is the time for men and women of Medicine—and of all other professions and walks of life—to see conditions as they really are, to face up to facts, and to do the job. In Medicine our task is to advance constantly the standards of health care, and to cooperate in the effort, through voluntary health insurance coverage, to keep health care within the reach of all. All well and able citizens should be encouraged to help themselves, and government should help those—and only those —who are unable to help themselves.

Each member of the profession must be exacting toward himself in the effort to provide and keep available the best possible service. Let each of us put aside all smug complacency, indifference, and caviling self-interest, and, by constructive and cooperative efforts, do all in our power to well serve the needs of the people and the good of our country, and to advance the profession, as an entity, in the public esteem and affection.

At a time when our adversaries, ". . . breathing like sanctified and pious bawds, the better to beguile," are doing all in their power to undermine the respect and confidence of the American people in their doctors and in the free practice of medicine, it is especially important that we manifest a spirit of unity and harmony within the profession. In this spirit we can and should work unitedly within the profession for the advancement of the profession as a whole. In this spirit we shall avoid the danger of giving aid and comfort to the enemy.

What our country really needs today is men and women who are both magnanimous and magnificent, equipped to discredit and sweep away the shallow and presumptous small-minded reactionaries who would deprive us Americans of our birthright of freedom and responsibility and reduce us instead to dependence upon their favored type of mealy-mouthed tyranny.

Let us prove ourselves men and women of such stamp, and let us take our stand with our like-minded fellow Americans, wherever and whomever they may be—alienating none, but winning all to join in the fight to make sure that American freedom will neither fade nor fail, but instead will flourish and triumph as an inspiration and a hope to all the world!

315 West State Street

Trustees' Meeting

NOVEMBER 18, 1962

A regular meeting of the Board of Trustees was held on Sunday, November 18, 1962. Following is a summary of the relevant significant actions which were taken.

REPRESENTATIVES NAMED . . . Designated the following to represent MSNJ as indicated:

1) AMA Congress on Occupational Health —Boston, October 2-3—Doctor Mathilda R. Vaschak, a member of the Society's Special Committee on Occupational Health.

2) Economics of the Pharmaceutical Industry—Union, October 25—Doctor Charles Calvin, First Vice-President.

3) Planning Meeting for Mental Health Conference—Montclair, October 25—Doctor Lloyd Morrow, a member of the Special Committee on Mental Health.

COMPENSATION OF INTERNS AND RESIDENTS . . . Received from the Union County Medical Society a resolution opposing the recommendations of the AMA Council on Medical Education and Hospitals and the Council on Medical Service as contained in a report on this subject . . . directed that the New Jersey Delegation to the AMA introduce the following resolution in opposition to this report:

Whereas, this House of Delegates has before it a special report submitted by the Council on Medical Education and Hospitals and the Council on Medical Service dealing with the subject "Compensation of Interns and Residents"; and

Whereas, one of the features of that report is a suggestion that hospital attending staff members legally associate, for the purpose of employing and compensating house officers, for services rendered to hospital patients; and

Whereas, such action would inescapably invite hospitals to participate further in the corporate practice of medicine; and

Whereas, the report further suggests that patients who have purchased private voluntary medical-surgical insurance coverage should be cared for by house officers compensated by means of that coverage, despite the fact that most holders of such coverage have bought it to escape exposure to clinic care and to enjoy the services of the private physicians of their choice; and

Whereas, these suggestions disregard the accepted principle that hospitals, and not the members of their attending staffs, are responsible for the employment and compensation of hospital house officers; now therefore be it

Resolved, that this House of Delegates reaffirm and re-emphasize its recognition of the principle that it is the responsibility and duty of attending staff members to teach, guide, and counsel the house officers, but not, however, to the extent of compensating those house officers for submitting to such teaching, guidance and counseling; and be it further

Resolved, that this House of Delegates reaffirm its recognition of the historical fact that it is the responsibility of hospitals to employ and properly compensate their house officers for services rendered; and be it further

Resolved, that the members of the medical profession now assume increasing responsibility to induce hospitals and communities, in the interest of justice and the recognition of worth, to compensate house officers on a scale proper to their education accomplishments and professional abilities.

AMA CLINICAL SESSIONS . . . Authorized the introduction in the AMA House of Delegates at the forthcoming interim session in Los Angeles the following resolution:

Whereas, the Annual Clinical Sessions of the AMA now occur at a time of the year, weatherwise and holidaywise, that is very inconvenient for those obliged or expected to attend; and

Whereas, these clinical sessions are regularly held in locations that impose heavy travel ex-

penses upon the majority of members of the House of Delegates and upon the officers and staff of the American Medical Association, not infrequently necessitating transcontinental travel; and

Whereas, because of the geographical location of such sessions, and of the cost, time, and trouble involved, relatively few physicians—except members of the AMA House of Delegates and physicians from neighboring areas—attend; therefore be it

Resolved, that clinical sessions of the AMA as presently conducted be discontinued as soon as contract commitments will permit, and a practical substitute—such as regional clinical sessions under AMA auspices—be supplied instead, and be it further

Resolved, that the AMA House of Delegates hold an interim session each year in Chicago —as centrally located and the home of the American Medical Association—at some time early in the calendar year convenient to the members of the House, and in accordance with a compact meeting schedule carefully worked out to minimize the time to be consumed.

HOUSE OF DELEGATES . . . Directed that the Secretary set up a mechanism to cover the attendance record at the 1963 House of Delegates in conjunction with the final session, which is to convene at 9:00 a.m., recess at 11:30 a.m., and reconvene at 1:30 p.m. On this basis the Board agreed that the sessions of the House of Delegates should continue to be three in number, but that the strip-attendance card issued to delegates should be in four parts—with the third session divided into two parts.

JOINT COUNCIL TO IMPROVE THE HEALTH CARE OF THE AGED . . . Approved—at the request of the President—the establishment of a program of education and cooperation between agencies represented on the Joint Council to improve patient care in nursing homes in New Jersey; its Chairman, Doctor David Eckstein, is to keep the Board informed of the program's development.

POLICY GOVERNING AMA NEWS RELEASES . . . Directed that the New Jersey Delegation introduce the following resolution at the AMA Clinical Session:

Whereas, in consequence the public and the profession were led to believe that this program of compensation had official AMA approval, when in fact it had not; and

Whereas, the free deliberations of this House of Delegates, in connection with the special report of the Council on Medical Education and Hospitals and the Council on Medical Service have been in consequence inexcusably embarrassed and prejudiced; now therefore be it

Resolved, that this House of Delegates summarily direct that in future, no reports or proposals to be submitted to it be thus released and/or adjudged until the House has committed itself officially in connection therewith.

WORKMEN'S COMPENSATION HEARING . . . Directed that the practice of Workmen's Compensation medicine in New Jersey be studied, that the results of the study and/or recommendations be reported to the Board as early as possible, and that this be an assigned project to the Special Committee on Workmen's Compensation augmented by three members from the Board (Doctors Ralph M. L. Buchanan, Thomas C. DeCecio, and Marcus H. Greifinger), the Chairman of the Special Committee on Occupational Health, and the Chairman of the Council on Legislation.

THE JOURNAL . . . Adopted the following recommendations—effective June 1, 1963 —of the Publication Committee:

1) Prescription Pharmacists' Listing—That this particular form of advertising be discontinued.

2) Representative Funeral Directors—That this form of advertising be discontinued.

3) Respiratory Diseases Abstracts—That the cost of printing these two pages be ascertained, and that the New Jersey Health and Tuberculosis Association be asked to cover this cost.

4) Subscription Rate—(a) That the subscription rate be increased to $5 per year, or 50 cents per issue.

(b) That copies of back issues more than two years old be sold, when available, at $1 each, plus postage.

(c) That subscriptions be paid in advance, in compliance with AMA policy.

5) Foreign Subscriptions—That each request for foreign subscriptions be considered on an individual basis. If it is desirable to grant the request, the regular subscription

rate, plus additional cost of postage, will apply.

6) Discounts for Subscriptions—That discounts no longer be given for subscriptions.

7) Reprints—(a) That the policy of free copies of THE JOURNAL be discontinued.
(b) That, if at any time, extra copies are ordered for other than the membership and regular subscribers, this cost be absorbed directly by the group involved.

8) Advertising Contract—That each and every contract received be cleared with, and be signed by, the Chairman of the Publication Committee.

9) Bad Debts—That it be the policy of the Publication Committee to discontinue any advertisement and to decline future advertising from any advertiser whose bill remains unpaid after a three-month interval.

. . . Deferred action on other recommendations concerning an increase in the advertising rates until after the Committee has reviewed the report of the Assistant Editor on the recent Conference of Journal Editors in Denver.

STAFF POLICIES COMMITTEE . . . Received the report (authorized by the Board in September) of Andersen & Company of New York—the firm engaged to review (and if necessary, to make recommendations concerning)—the Society's financial procedures, budgeting, and general fiscal policies . . . Referred the report to the Staff Policies Committee for piecemeal study and subsequent recommendations.

Obituaries • • •

DR. FRANK L. FIELD

One of the longest medical careers in the nation was terminated on December 17, 1962 with the death that day of Dr. Frank L. Field. He was born in 1870 when Ulysses S. Grant was President. He received his M.D. at Bellevue in 1893 and after brief service as a ship's physician, he went to rural Somerset County. For three decades he was the only medical practitioner in Far Hills or Bedminster. He was the first school physician there. He was the oldest member of our Somerset County component Society. From 1893 until he entered the Army in 1917 he was literally a horse and buggy doctor. Dr. Field was one of the first civilians to join the medical corps during World War I and he spent most of that period in France. He was probably the first medical officer assigned to the then new-born "Arm A, Army Air Corps." (This was in 1917!)

DR. FRANCIS F. HAGGERTY

On December 14, 1962 a fire took the life of Dr. Francis F. Haggerty, Associate Surgeon at Hoboken's St. Mary's Hospital. Dr. Haggerty was a life-long resident of Hoboken, where he was born in 1904. He received his M.D. at Georgetown in 1930. He was active in committee work with the Hudson County Medical Society and was on the surgical staff at the Margaret Hague Hospital.

DR. SAMUEL H. HUSTED

Dr. Samuel H. Husted of Neshanic died suddenly at his home on December 26, 1962. Dr. Husted, a native of Newport, was the founder of the Foothill Acres Nursing Home which he built in 1954. Born in 1900, he received his M.D. at the University of Maryland in 1929. After doing surgical and general practice in the Somerville area for many years, he settled in Neshanic Station. He remained actively on the staff of the surgical service of the Somerset Hospital.

DR. EMIL L. SANTANGELO

Dr. Emil Ludwig Santangelo died suddenly at his Paterson home on December 11, 1962. Born in Paterson in 1903, he was graduated in 1928 from the medical school of Georgetown University in Washington. He served as a major in the medical corps in the European theatre during World War II. An FACS, he was active in the affairs of the Passaic County Medical Society and was on the surgical staff of St. Joseph's Hospital.

Announcements • • •

Chest Physicians Meet Here

This year the American College of Chest Physicians meets in Atlantic City. The convention opens at the Ambassador Hotel on June 13. For details of the program, write to Executive Director, College of Chest Physicians, 112 East Chestnut Street, Chicago 11.

School Health Symposium

You are invited to a late afternoon meeting on the physician's role in school health, to be held on Wednesday, March 27, at the Edgebrook Restaurant just outside of New Brunswick. The restaurant is at the intersection of Routes 1 and 18, one-half mile west of Exit 9 of the New Jersey Turnpike.

The symposium will start at 4:00 p.m., under the chairmanship of Geoffry W. Esty, M.D., of the State Department of Education. Speakers include Robert E. Jennings, M.D., chairman of the Child Health Committee of The Medical Society of New Jersey; C. Stuart Littwin, M.D., chairman of the Committee on Conservation of Vision of the Bergen County Medical Society; Aris M. Sophocles, M.D., director of the Hearing Center at Mercer Hospital in Trenton; and Curtis F. Culp, M.D., director of the Division of Constructive Health of the Health Department. The evening speaker will be Donald A. Dukelow, M.D., of the Health Education Department of the AMA.

Serological Test for Toxoplasmosis

On or about March 1, 1963, the State Health Department Laboratories will begin a project for evaluating a serological test for Toxoplasmosis (Fluorescent inhibition test). Specimens from suspected congenital cases and their mothers or from eye lesion cases will be eligible.

For further information write: E. L. Shaffer, Ph.D., Director of Laboratories, State House, P.O. Box 1540, Trenton 25, New Jersey.

A Chance to Go to Burma

If you are interested in surgery, and want a different, dedicated and challenging experience, you may qualify for working with Dr. Gordon Seagrave in Burma. The candidate must be an American citizen under the age of 40, an alumnus of a grade A medical school. The successful candidate will leave for Burma in April or May 1963. His experience at Burma will be varied and he will see some conditions rare in the United States. Travel expenses will be provided, and the housing is described as "Western style." A wife who can serve as nurse or school teacher will be doubly welcome. The salary is listed as "modest"—amount not specified. If interested, write to American Medical Center for Burma, 6 Penn Center Plaza, Philadelphia 3, Pennsylvania.

Alcoholism Symposium

An all-day workshop on alcoholism has been scheduled for Thursday, April 4, at the Essex County Overbrook Hospital in Cedar Grove. The meeting will cover the medical, psychological, pharmacological, and legal aspects of alcoholism. Provision has been made for discussion from the floor and for meeting in small discussion groups. There is no registration fee.

The program starts at 9:30 a.m. and will terminate at 4:30 p.m. The Essex County Overbrook Hospital is in Cedar Grove, immediately west of Montclair and north of Verona.

Intensive Pediatric Course

General practitioners, internists and pediatricians will be interested in an intensive five-day refresher in pediatrics starting May 27 and terminating May 31. This is given at and by the Children's Hospital at 1740 Bainbridge Street, Philadelphia 46. Tuition is $150. For details write to the Graduate Education Committee at that address.

Psychosomatic Profile • • •

"On Communication"

Patients, being people, express their meanings one to another in a good many ways. One can say simply and directly "I like you"; one can smile and with a caress convey the same message non-verbally. The pompous may speak in riddles, the savage in symbols, the lover in opposites, the insecure in hyperboles and the sophisticate in understatement. Psychoneurosis may communicate through the "organ language" of physiologic activity. Depression often uses silence. As physicians, we are presumably trained to seek substance in all of these "languages." Skill in psychosomatic practice varies directly with the ability to separate what "he means" from what "he says."

And yet there are times, often critical moments, when meaning is crystal clear and when failure to understand results not from the obliquity of the message but from the blindness of those who must receive it. Take the case of Jim Cooper, 23-year old mechanic, who walked into his fiancee's apartment on an April day in 1957 and shot her dead.

In a brilliant article published in the *American Journal of Psychiatry*, October 1961, attorney Frederick Wiseman of Boston discusses what followed in terms of some of the legal absurdities of our times. He hints, too, at the several dilemmas of expert psychiatric testimony. Beneath the science and the legalisms one senses the fundamental tragedy: the pathetic failure of communication.

At his trial, young Cooper insisted that his girl's vacillation concerning marriage forced him to commit the act; and that somehow he always knew he'd end up "in the chair." State psychiatric authorities judged him sane. Brigg's Law examiners found him clear, nondelusional, competent, and able to stand trial. Psychiatrists for the prosecution labeled him aware of his deed and its consequences, and diagnosed "personality disorder." An expert for the defense brought out a long history of feelings of isolation, the boy's guilt-laden belief that he had been responsible for his father's accidental death, several serious semi-suicidal accidents in childhood, and a conviction that the death of two pilots was the result of his poor mechanical work on their plane.

Judge and jury struggled as laymen with the complexities of psychiatric nomenclature, with Rorschach concepts which confound even advanced students, and with testimony about subconscious drives and symbolism which even some physicians are still unprepared to deal with. Cooper responded to the verdict of guilty and sentence of death by electrocution with "thank you."

But society and the judicial process are uneasy about the heretofore accepted tests of sanity and guilt. Defense, family, and powerful groups petitioned the governor for commutation while Cooper implored that sentence be allowed to stand. He was re-examined by a group of psychiatrists who concluded he was treatable and had acted through irresistible compulsion. The prisoner continued to beg for death, which he apparently conceptualized as inevitable and as expiation of guilt. The governor decided in favor of commutation. Jim Cooper then hanged himself.

There had been endless testing, multiple interviews, and a tremendous concentration of psychiatric talent. All somehow failed to hear what Cooper had to say quite clearly and simply in his acts and in his verbal declarations. Communication which might have been simply consummated failed because it was assumed that meanings so naively expressed could not be valid.

Mr. Wiseman ends his article with a poem written by Cooper several weeks before his suicide. Had the examiners seen it, would the communication circuits have then been complete?

"Sunlight in patterns,
Rectangular shapes,
Covers my floor.
Moonlight imprisoned,
Slantingly gapes
Through my door.
Night air comes creeping
Through the small windows
Cold, fresh and free;
Willingly captured, like
Schools of small minnows,
Coming to me.
Starlight is filtered
Through dirty glass,
Soiling the sky.
And time is hollow
Never will pass,
Unless I die.
Where am I?"

—Sanford H. Lewis, M.D.

Book Reviews

Surgery of the Ambulatory Child. S. Frank Redo, M.D. New York, 1961. Appleton-Century Crofts, Inc. Pp. 340. ($8.25)

This short volume achieves its purpose in providing guide posts for all physicians who render surgical care to children. The book is well written and the volume is attractive.

The criteria for the selection of patients for ambulatory care are helpfully defined throughout. The author permits the "common sense" of the attending physician to play a role in total care. Dr. Redo realizes that the commonly quoted "rule of nines" for estimating the surface of a burn does not apply to children. He offers a practical substitute.

The section on care of iatrogenic stomata is very good and much needed in reference to children.

ROBERT K. SPIRO, M.D.

Accident Prevention. American Public Health Association. New York, 1961. Blakiston. Pp. 400. ($12.00)

Many articles, symposia, and texts of various calibre of excellence have been written about accident prevention. One hails the worthy calibre of this book which includes 21 chapters by some 37 authorities—each with skill in some portion of the subject. The ordering of the chapters from the first one on "The Magnitude of the Problem" to the last one on "Research" shows fine organization in guiding the reader from generalities through specifics to future needs.

Some repetition also appears throughout the chapters, but the editor wisely points out that to keep many chapters self-contained, some repetition was necessary.

One aim of this book is to place before physicians and public health workers the opinions and points of view of experts in the field of safety, with more than usual emphasis on the basic group of human factors: the *physical, psychologic,* and *physiologic.* Another purpose is to make it, in its comprehensive nature available not only to physicians and public health workers, but also to medical students and para-medical personnel including safety councils and teachers, as well as non-medical persons responsible for safety in varied occupations.

Of especial note is the timely share of emphasis placed on off-the-job accident prevention. This is well discussed in the chapters on "Home Safety," "School Safety," and "Recreational Safety." The book includes many charts, graphs, diagrams, and other pictorial media which, in the main are clear-cut, to the point, and understandable. References at the end of each chapter are specific, selective, and concise—limited, but very adequate.

In the final chapter "Research," a sage statement is made: "The subject matter of present research is less important than the intent to do research."

Because this text is so well written and covers so comprehensively such a wide scope of accident prevention, it should be in the library of all persons interested in the subject.

D. W. CALDWELL, M.D.

Prognosis After Sterilization on Social and Psychiatric Grounds. Martin Ekblad. Copenhagen, 1961. Ejnar Munksgaard. (Supplement to Volume 37 of *Acta Psychiatrica Scandinavica*). Pp. 162. (20 Danish kroner)

Legal abortion too often affords a "temporary and . . . rather meaningless respite" from pregnancy, in the opinion of this Swedish psychiatrist. Dr. Ekblad urges that sterilization be considered in every legal abortion. Eighty-five per cent in his series of mostly "socially respectable" Stockholm women were pregnant at the time of salpingectomy and were aborted at the same time. A third had undergone at least one previous abortion.

All the women were sterilized in the Swedish capital in 1951 and practically all were personally interviewed by Dr. Ekblad five or six years later.

Half the subjects presented psychoneuroses or abnormal personality traits at the time of operation. Yet, in retrospect, only 15 expressed real regrets—and a third said they were deriving greater satisfaction from their sexual relationships. This, he believes, is clinically important, since many physicians think twice about what will happen later to an already unstable or neurotic patient. Better worry about the psyches of the childless, he advises; adding that the possession of even one child "seems to diminish the risk of dissatisfaction."

Dr. Ekblad's inquiry is exhaustive; he breaks down his findings 37 ways from Sunday. Much of the report reads like a Gallup Poll in depth, or a sociologic dissertation. Sometimes it leaves the reader up a fjord without a paddle. On page 68, for instance: "Of the women who (at the time of the follow-up examination) were living harmoniously with the same man as before the sterilization, 92 per cent were wholly satisfied with the sterilization, against 73 per cent of the women who were still living with the same man but *not* harmoniously and against 71 per cent of the women who were no longer living with the partner they had had before the sterilization."

More endearing are the individual histories pre- and postoperative, on some 61 women in the series. These stories behind the salpingectomy yield more insight than all the frequency tables. Chapter 1, on the Swedish Sterilization Act and its application, provides much cultural prognosis.

FRADLEY GARNER

Forensic Medicine. Keith Simpson, M.D. Baltimore, 1961. Williams and Wilkins. Ed. 4. Pp. 355 with 138 illustrations. ($7.50)

Since 1946, Simpson's *Forensic Medicine* has been accepted by both British and American practitioners as a compact and authoritative handbook of toxicology and the interpretation of human injury. The present, fourth edition brings the book up to date with new data about tranquilizers, poisons and motor vehicle injuries. The text includes material on blood stains, infanticides, identification of the living and dead, ballistics and autopsies (in Britain the fee is 4 guineas per autopsy, plus an extra 2 guineas for furnishing the report and 3 guineas for each court appearance. A guinea is about $3). The book is illustrated by 138 pictures, many of them gruesome. The 80-page section on toxicology is a complete little monograph in itself. The British flavor of the book reduces the usefulness of its statutory citations and its account of legal procedure; but this does not in any way affect the usefulness and validity of its many medical descriptions. Some of us may be interested in Dr. Simpson's frequent sermonizing. Thus, his comment on homosexuality: "These practices are rotting the fabric of the arts as well as the more solid principles of family life, and the law properly regards such sex practices with a stern eye." If the doctor is in doubt about the propriety of a certain course, Simpson remarks that "the advice of an experienced secretary of a defence society (insurance company?) is better than a chat over a drink with a colleague at the club." There will always be an England.

HENRY A. DAVIDSON, M.D.

Atlas of Surgical Operations. R. M. Zollinger, M.D. and Elliott C. Cutler, M.D. New York, 1961. Macmillan. Third Ed. Pp. 235 with 110 plates and 300 line drawings. ($18.00)

The authors have aptly stated the reason for, and the need of, a surgical atlas: to serve as a review for the surgeon the night before his surgery, and the presentation, particularly to the young surgeon, of basic general surgery. Also a surgical atlas has to present procedures in detail indicating that the authors prefer methods which have proved satisfactory in their practice and teaching.

The light-blue paper on which the print and illustrations have been placed should prove to be a popular innovation. The authors' chapter on "Surgical Technic" should be read by every surgeon in our routine competitive practice of private surgery. We are prone to overlook many principles which affect our operative morbidity for the sake of "getting the job done." As the authors state, the Halstead "school for safety in surgery" does not permit carelessness nor does it condone speed of procedures. The chapters on "Anesthesia" and "Preoperative Preparation and Postoperative Care" need no comment other than to state that they are excellent and certainly necessary to any surgical atlas. Routine operative procedures are well described and illustrated. The color illustrations of the anatomic relations of the upper abdominal viscera, the large intestine, the abdominal aorta and inferior vena cava are a valuable addition over the previous editions. I anticipate that the authors will include more such color prints and possibly make the fourth edition entirely in color.

When surgeons describe technics they invite criticism from those who differ. I would be remiss in reviewing this Atlas if I failed to call attention to these differences of opinion. The longitudinal skin incision for a tracheotomy, failing to mention the use of constant suction following a radical mastectomy, making no mention of plastic mesh as a prosthesis to assist in the repair of large abdominal wall defects merely indicates that many surgeons differ in their opinions regarding surgical technics.

This "Atlas of Surgical Operations" serves its purpose and should be included in all medical libraries. It will be a valuable asset to any surgeon's bedside reading.

HARRISON R. WESSON, M.D.

Finger Prints, Palms and Soles: An Introduction to Dermatoglyphics. Harold Cummins. Ph.D. and Charles Midlo, M.D. New York, 1962. Dover Publications. Pp. 319. ($1.95)

The authors, from the anatomy department at Tulane, describe the development and differentiation of skin ridges and creases on fingers, palms and soles. They include a history of the development of dermatoglyphics and discuss the possibility of using these patterns in determination of paternity. They have assembled reports which assert that dermatoglyphics may occasionally help in the diagnosis of chronic mental diseases, poliomyelitis, and "criminal tendencies." The embryology of the skin pads is reviewed. The mechanics and statistics of identification technics are also presented. The book includes 150 illustrations.

ABRAHAM LEFF, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

FEBRUARY, 1963 • VOL. XXXVI, NO. 2

RESPIRATORY ABNORMALITIES IN EOSINOPHILIC GRANULOMA OF THE LUNG

Five cases of this lung condition, which is rare but on the increase, were followed by physiologic studies for from two to nine years. Mechanics of breathing were normal in most of the subjects, but there was severe impairment of diffusing capacity and marked ventilation-perfusion discrepancies. Diagnosis can be made with certainty only by lung biopsy.

Interstitial and perivascular granulomas, surrounded by eosinophiles and histiocytes, scattered at random throughout the lung parenchyma, constitute the pathologic pattern of pulmonary eosinophilic granuloma. The expected physiologic derangements would be alterations in intrapulmonary distribution of gas and blood, impairment of gas diffusion across the alveolocapillary membrane, and alterations in the mechanical properties of the lungs.

The present report is based on study of five cases of eosinophilic granuloma confined to the lungs in which extensive clinical and physiologic measurements were made at intervals up to nine years.

FUNCTION TESTS

Spirograms were recorded and from these the fast vital capacity (VC) and its subdivisions and the maximum midexpiratory flow (MMEF) were obtained. The maximum breathing capacity (MBC) was measured also.

Pulmonary compliance was calculated from simultaneous records of volume and intraesophageal pressure.

All blood and gas collections were made during steady-state conditions, with the subject supine after resting for at least 20 minutes, and during exercise on a treadmill. Diffusing capacity was measured by O_2 and CO methods, both by single breath and during steady breathing.

Observations were made at intervals of four weeks to eight and five-tenths years.

CHARACTERISTIC LESIONS

Lesions found in all five cases were characteristic. Small, gray-white, firm nodules were scattered throughout the parenchyma of the lungs. Histologic patterns varied considerably, depending upon the stage of the disease. Most of the granulomas occurred in interstitial tissue. Arteriolitis was common and focal involvement of small airways was also noted. In one case "bronchiolitis" was more prominent than in the other cases. In some specimens areas of fibrosis were interspersed with active granulomas, and focal emphysema surrounded these areas.

One case provided an opportunity to study two stages of eosinophilic granuloma of the lung. In 1955 nodular parenchymal lesions and many subpleural blebs were found by lung biopsy. The microscopical anatomy was typical of eosinophilic granuloma although fibrous tissue was prominent.

Two years later the pattern found at autopsy

Lt. Commander Lee Hoffman (MC) USNR, Jerome E. Cohn, M.D., and Edward A. Gaensler, M.D., *The New England Journal of Medicine*, September 20, 1962.

was vastly different. The lung was stiff and noncollapsing. Whole-lung sections demonstrated an irregular pattern of air spaces varying in size up to 1 cm. in diameter, interspersed with blood vessels of many sizes. Thick bands of mature fibrous tissue separated dilated air spaces and vascular channels. The cystic spaces, lined with respiratory epithelial cells of fibrous tissue, may have represented dilated bronchioles, coalesced alveolar spaces or newly formed sacs. No unequivocal evidence of eosinophilic granuloma was found at this stage. The hilar lymph nodes were normal. No lesions were found in the hypothalamic-hypophyseal system.

Without the previous biopsy a specific cause for the widespread alteration of lung architecture could not have been ascertained, and this is the stage of disease called "honeycomb lung" by J. Gough and others. The suspicion of eosinophilic granuloma arises then only if the patient also had diabetes insipidus.

PATHOPHYSIOLOGY

The physiologic observations can be considered in terms of the pathologic findings. The earliest documented phase of pulmonary eosinophilic granuloma is characterized by a diffuse infiltrative process encroaching upon air spaces and small blood vessels. This leads to decrease in lung compliance and diminished lung volumes. As the process clears the lung compartments enlarge. Normal mechanics of breathing was a characteristic finding in nearly all subjects in serial studies.

Only one case had some decrease in expiratory flow rates initially. In the final stage of the disease the terminal airways were markedly distorted. However, the supporting structures of these conduits were not lost as they are in emphysema. Thus, airway resistance remains low and ventilatory capacity high.

Impaired alveolocapillary diffusion in eosinophilic granuloma may result from two distinct but often associated processes. During the active phase of the disease interstitial lesions may thicken the membrane and increase the barrier to gas exchange. Damage to pulmonary arterioles may decrease the number of effective, perfused capillaries and thereby reduce the surface area of effective alveolocapillary membrane available for gaseous diffusion.

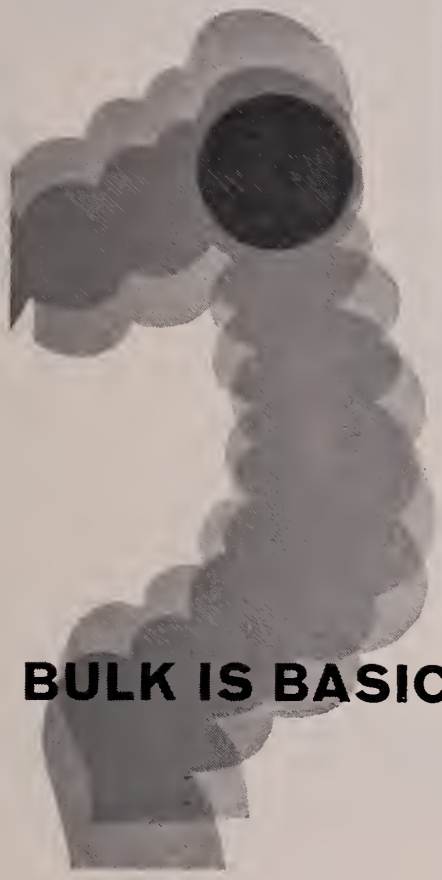
INCIDENCE

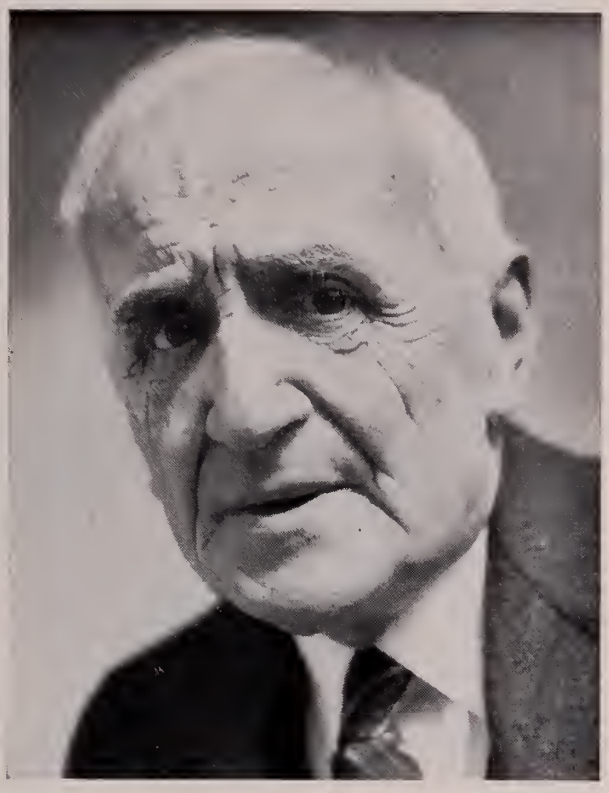
The incidence of eosinophilic granuloma is unknown. Cases have been reported with increasing frequency in recent years. This may be the result of more common use of lung biopsy in the diagnosis of diffuse lesions of the lung. There are no pathognomonic clinical, radiographic, or physiologic features. The disease usually occurs in white men between 20 and 40 years of age. Although the course is usually benign and self-limited, pulmonary insufficiency of varying degrees may ensue. Nonspecific pulmonary fibrosis may be a consequence of eosinophilic granuloma.

Histological examination of lung tissue is essential for diagnosis. Scalene adenectomy has proved useless in cases reported. An assumed association between proved eosinophilic granuloma of bone and a pulmonary infiltrate seen on x-ray study, although reasonable, can be misleading. About 28 per cent of all cases have had one or more episodes of spontaneous pneumothorax, and diabetes insipidus has been reported in 21 per cent of cases but was not found in this series.

One patient treated with large doses of adrenocorticosteroid drugs showed marked improvement in all modalities of function and rapid clearing of the roentgenogram of the chest. In 3 other patients x-ray clearing was less well related to functional changes, and clinical improvement occurred during periods without treatment. Radiation therapy in one case caused no improvement.

NEW JERSEY TUBERCULOSIS AND HEALTH ASSOCIATION
15 EAST KINNEY STREET, NEWARK 2, NEW JERSEY





BULK IS BASIC

in geriatric constipation

METAMUCIL®

adds tone to the atonic colon

Metamucil, refined hydrophilic mucilloid, is especially suited to correct the kind of constipation most frequently encountered in elderly patients.

Metamucil adds soft bulk to the often inadequate diets of older persons and supplies the gentle intracolonic pressure needed to induce normal peristaltic action.

This true physiologic stimulus increases muscle tone, encourages normal reflex activity and helps reestablish the natural rhythmic function of the bowel. Only a soft bulk stimulus like Metamucil offers such natural encouragement to normal evacuation.

Metamucil is available as Metamucil powder in 4, 8 and 16 oz. containers and as lemon-flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

METAMUCIL®

brand of psyllium hydrophilic mucilloid

G. D. SEARLE & CO.

CHICAGO 80, ILLINOIS

Research in the Service of Medicine

the right combination



. . . safe, effective antihypertensive therapy

Rauprote

(Rauwolfia serpentina and Protoveratrines A and B combined)

Rauprote combines two effective antihypertensive agents—*Rauwolfia serpentina* for moderate tranquillizing and gentle hypotensive effect, and Protoveratrines A and B for faster, more potent lowering of blood pressure and bradycrotic action. The combination produces a therapeutic hypotensive effect which is superior to larger doses of either drug alone; reduced dosage of both components minimizes or eliminates toxic side effects completely.[1,2]

Clinical studies show the majority of patients suffering from significant elevation of blood pressure achieve an excellent response to this combination.[2]

Rauprote is indicated in management of moderate to severe essential hypertension.

Supplied:

In bottles of 100 and 1,000 tablets, each tablet containing 50 mg. *Rauwolfia serpentina* and 0.2 mg. Protoveratrines A and B (alkaloids of *Veratrum album*).

1. Goodman, L.S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., Macmillan & Co., New York (1955).

2. Roberts, E.: Four Year Evaluation of an Antihypertensive Agent, J. Am. Med. Women's Assn. *13*:349 (1958).

THE VALE CHEMICAL CO., INC.

VALE

Pharmaceuticals since 1922

Allentown, Pennsylvania

REPRESENTATIVE FUNERAL DIRECTORS

OF THE STATE OF NEW JERSEY

Special and Dependable Service Day and Night. Special Attention Given to Hospital Calls, Train and Express Shipments.

Place	Name and Address	Telephone
ADELPHIA	C. H. T. Clayton & Son	FReehold 8-0583
BLOOMFIELD	George Van Tassel's Community Funeral Home	PIlgrim 3-1234
BOONTON	Lewis & Carey Incorporated, 312 W. Main St.	DEerfield 4-0842
CRANBURY	A. S. Cole Son & Co., Main St.	EXport 5-0770
ELIZABETH	Aug. F. Schmidt & Son, 139 Westfield Ave.	ELizabeth 2-2268
ENGLEWOOD	Greenleaf Funeral Home, Inc., 108 W. Palisade Ave.	LOwell 8-0416
FREEHOLD	Higgins Memorial Home, 20 Center St.	HOpkins 2-0895
JERSEY CITY	McLaughlin Funeral Home, 591 Jersey Ave.	OLdfield 3-2266
LINDEN	Don McCracken Funeral Home, 2124 St. Georges Ave.	ELizabeth 2-9190
METUCHEN	Runyon Mortuary, 568 Middlesex Ave.	LIberty 8-0149
NEWARK	Barrish Funeral Home, 684 Clinton Ave.	ESsex 3-1551—9179
PATERSON	Legg, R. Charles D. & Sons, 384 Broadway	SHerwood 2-2385
RAMSEY	The Harold Van Emburgh Funeral Home, Inc.	DAvis 7-0030
RIDGEWOOD	C. C. Van Emburgh, Inc., 306 E. Ridgewood Ave.	GIlbert 5-0344
RIVERDALE	George E. Richards, Newark Turnpike	TEmple 5-0164
SOUTH RIVER	Rezem Funeral Home, 190 Main St.	SOuth River 6-1191
TRENTON	Ivins & Taylor, Inc., 77 Prospect St.	EXport 4-5186

NOW! DIABETICS CAN ENJOY
(UNDER MEDICAL ADVICE)

Abbotts
ARTIFICIALLY SWEETENED
ICE CREAM

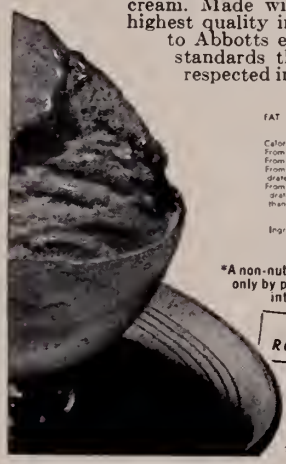
Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards — standards that are most highly respected in the dairy industry

COMPOSITION
FAT 10.52% PROTEIN 3.71%
CARBOHYDRATES 20.40%

		Oz. Avoir.	Oz. Fluid
Calories — Per 100 Gm.	191.42	54.27	32.95
From Fat	94.68	26.84	16.23
From Protein	14.84	4.21	2.55
From Carbohydrates as Lactose	20.24	5.74	3.47
From Carbohydrates other than Lactose	61.66	17.48	10.58

Ingredients: Cream, Milk, Sorbitol, Stabilizer and 0.11% Cyclamate Calcium*

*A non-nutritive artificial sweetener for use only by persons who must restrict their intake of ordinary sweets.



IN HANDY ROUND PINTS

At Abbotts and Jane Logan Dealers
Abbotts Dairies

DUGAN'S
"Bakers for the Home"

New - LITE DIET BREAD
(White Bread Baked Without Shortening)
Calories per Slice 42 Calories per oz. 70

ALSO

SALT-FREE BREAD
GLUTEN AND PROTEIN BREADS
100% WHOLE WHEAT
100% Whole Wheat Crackers

New York New Jersey
Connecticut Pennsylvania

"At Your Door or To Your Store
It's DUGAN'S for BETTER Baked Goods"

Phone for Delivery

HUmboldt 2-6007 in Newark
(or your local phone book for branch nearest you)

Ranch Type - Luxurious **THE PARKWAY NURSING HOME, INC.**



1201 PARKWAY AVE.
Trenton, N. J.
882-6900

No Steps!
New audio-visual intercom system from every patient to Nurses.

One of New Jersey's newest, most modern and completely equipped Nursing and Convalescent Homes, catering to the Convalescent, Aged, and Chronically Ill.

Referring physician has full medical privileges
Complete 24-hour general nursing care
Physical rehabilitation department
Beauty parlor — air-conditioned dining room, lounge, and lobby — spacious patios

Ultra modern interiors with artistic color scheme
Stainless steel kitchen tiled to ceiling
Special diets — planned social and recreational activities

Residential Section
Reasonable Rates

The Parkway Nursing Home

NEW JERSEY STATE LICENSED — MEMBER OF AMERICAN NURSING HOME ASSOCIATION

INFORMATION FOR READERS AND CONTRIBUTORS

The Journal is the official organ of The Medical Society of New Jersey, published monthly under the direction of the Committee on Publication. *The Journal* is released on or about the tenth of each month, and a copy is sent to each member of the Society.

Change of Address: Notice of change of address should be sent promptly to The Medical Society of New Jersey, P.O. Box 904, Trenton 5, New Jersey.

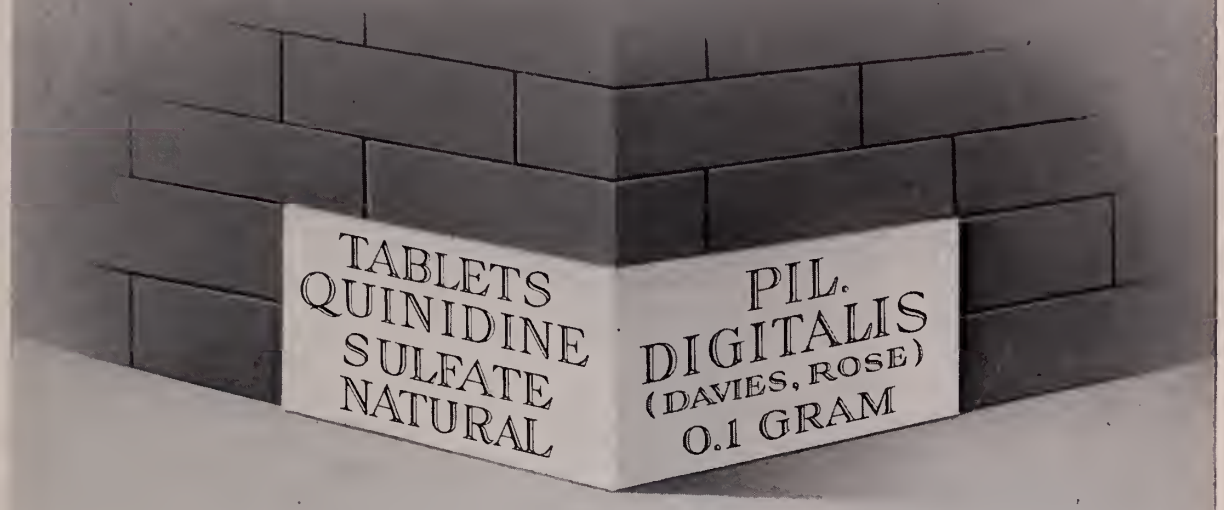
Communications: Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of any material in *The Journal*. All such communications should be directed to the Editorial Office of *The Journal*. The Publication Committee reserves the right to publish, reject, edit or abbreviate all communications submitted to it.

Contributions: Manuscripts submitted to *The Journal* should be typewritten, double-spaced on letter size (about 8¼ by 11 inch) paper and forwarded to the Editorial Office at the address below. The Publication Committee expressly reserves the right to reject any contributions, whether solicited or not; and the right to abbreviate or edit such contributions in conformity with the needs and requirements of *The Journal*. Galley-proofs of edited or abbreviated manuscripts will be submitted to authors for approval before publication. Every care will be taken with the submitted material, but *The Journal* will not hold itself responsible for loss or damage to manuscripts. Authors are required to submit original copies only, and are urged to keep carbon copies for reference. It is understood that material is submitted here for exclusive publication in this *Journal*.

Illustrations: Authors wishing illustrations for their articles will submit glossy prints or original sketches, from which cuts or plates will be made by *The Journal*. The cost of making such cuts will be borne by the author, who will, after publication, receive the cuts for his own use. The cost of these cuts varies with the size and type of the illustration. An estimate of the cost will be submitted to authors before the cuts are ordered.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY
P. O. Box 904, Trenton 5, New Jersey

A CORNERSTONE OF CARDIAC THERAPY



The Dictionary defines a cornerstone as something of fundamental importance, just as Pil. Digitalis, (Davies, Rose) and Tablets Quinidine Sulfate Natural (Davies, Rose) are of fundamental importance in treating your cardiac patients. These preparations represent 60 years of experience and dependability in the manufacture of pharmaceuticals.

Pil. Digitalis (Davies, Rose), 0.1 Gram (approx. 1½ grains) which comprise the entire properties of the leaf, provide a dependable and effective means of digitalizing the cardiac patient, and of maintaining the necessary saturation.

Tablets Quinidine Sulfate Natural, 0.2 Gram (approx. 3 grains) are alkaloidally assayed and standardized, insuring uniformity and therapeutic dependability. Each tablet is scored for the convenient administration of half dosages.

Davies, Rose & Company, Limited - Boston 18, Mass.

DQ-2

"Prescribe with Confidence"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR
FOR MEN - WOMEN - CHILDREN



SOLD ON Rx ONLY
OUTFLAIR SHOES
FOR CLUB FEET

177A JEFFERSON AVE.
PASSAIC, N. J.

69 WESTWOOD AVE.
WESTWOOD, N. J.

350 MAIN ST.
HACKENSACK, N. J.

Dennis Brown Splints — in all sizes — carried in stock



A NATURAL Treatment For Gastro-Intestinal Disorders

An implantation of l. acidophilus bacilli in the digestive tract will frequently restore intestinal flora to a normal, healthy condition. Walker-Gordon Acidophilus (a 2% butterfat product made from Walker-Gordon Certified Milk) abounds in lactobacilli acidophilus . . . 500 million per ml. Write or phone for professional sample of Acidophilus and complete information.

Guaranteed Free of Penicillin

WALKER-GORDON ACIDOPHILUS

Walker-Gordon Certified Milk Farm, Plainsboro, N.J. SWinburne 9-1234

New York: WAlker 5-7300 ☆ Phila.: PEnnypacker 5-3465

Also Producers of Certified Raw, Pasteurized, Homogenized-Vit. D, Skimmed and Fresh Lo-Sodium Milks.

Available through leading Milk Dealers or write Walker-Gordon



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE-MARK®

LONG TERM AUTO LEASING

. . . A SERVICE ESPECIALLY PLANNED FOR DOCTORS!

M.D. PLATES FREE, TOO!

AAL LONG TERM SINGLE CAR AND FLEET RENTALS

Call ORange 6-7137 or

MAIL COUPON TODAY

Lease a brand new Cadillac or other fine car from American and you'll never **buy** again. Save money, time and trouble. One modest monthly payment takes care of everything . . . insurance, maintenance, repairs, depreciation . . . and the payments are 100% tax deductible! Borrow a car—free of charge—in case of accident or breakdown.

INCLUDES

- Registration and plates
- Full maintenance
- Insurance

Liability $250/$500,000
Property damage $20,000
Deductible collision,
fire and theft

AMERICAN AUTO LEASING COMPANY
120 Halsted St., East Orange, N. J.
Please send me the AAL Long Term Leasing Plan.

Wide Selection of '63 Models

Special requirements _____

_____

Name _____

Address _____

City _____ State _____

ALL YOU BUY IS GAS AND OIL

ASK FOR BROCHURE

AAL **AMERICAN AUTO LEASING COMPANY**

120 Halsted Street, East Orange, New Jersey • ORange 6-7137

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

Place	Name and Address	Telephone
BERGENFIELD	Horn's Pharmacy, 475 So. Washington Ave.	DUmont 4-1119
BLACKWOOD	Worrell's Pharmacy, 12 So. Black Horse Pike	CAnal 7-0430
BLOOMFIELD	Burgess Chemist, 56 Broad St.	PIlgrim 3-1005
BLOOMFIELD	Jay W. Clark, Pharmacist, 170 Broad St., Belleville Ave.	PIlgrim 3-4150
CLOSTER	Mid Town Pharmacy, 237 Closter Dock Road	PO. 8-0070
DUMONT	Lenrow's Pharmacy, Inc., 10 W. Madison Ave.	DUmont 4-0842-1500
EDISON TOWNSHIP	Walter's Pharmacy, 1034 Amboy Ave.	LIberty 8-2614
EMERSON	Emerson Pharmacy, 201 Kinderkamack Road	COlfax 2-4999
FARMINGDALE	Burke Rexall Drugs, Main St. opp. Bank & Post Office	WEbster 8-9051
FREEHOLD	Wood's Pharmacy, 2 E. Main St., cor. South	FReehold 8-0668
HIGHLANDS	Highlands Pharmacy, 148 Bay Ave.	872-1550
JERSEY CITY	J. B. Feinberg Pharmacy, 659 Newark Ave.	OLdfield 3-6376
JERSEY CITY	Fred T. Fiore, 14 Rose Ave.	DElaware 3-7509
JERSEY CITY	Honiberg Drug & Surgical Supply Co., 618 Newark Ave.	SWarthmore 8-6700
JERSEY CITY	Lauria's Pharmacy, 768 West Side Ave.	HEnderson 3-1519
KEYPORT	Sav-On-Drugs, J. Meisler, opp. Post Office.	COlfax 4-0904
LAKEWOOD	Burke Rexall Drugs, Cor. 4th and Monmouth	FOxcroft 3-7133
MILLTOWN	Milltown Pharmacy, 21 No. Main St.	MIlltown 8-0081
MILLVILLE	Richard H. Knowles Pharmacy, 600 No. High St.	TAylor 5-0721
MORRISVILLE, PA.	Pryor's Pharmacy, Bridge St. & Penna Ave.	Cypress 5-7416
MOUNT HOLLY	Mount Holly Pharmacy, 64 Main St.	AMherst 7-0453
NEWARK	Giannotto's Pharmacy, 195 First Ave.	HUmboldt 2-8220
NEWARK	Marquier's Pharmacy, Sanford and So. Orange Aves.	ESsex 3-7721
NEWARK	7th Avenue Pharmacy, Inc., 71 - 7th Ave.	HUmboldt 3-7676
NEW BRUNSWICK	Bode Pharmacy, 120 French St.	KIlmer 5-2676
NEW BRUNSWICK	Tobin's Drug Store, 335 George St.	CHarter 9-0780
NEW BRUNSWICK	Zajac's Pharmacy, 225 George St.	KIlmer 5-0582
OCEAN CITY	Selvagn's Pharmacy, 862 Asbury Ave.	OCean City 3535
ORANGE	Highland Pharmacy, 536 Freeman St.	ORange 3-1040
PASSAIC	Wollman Pharmacy, 143 Prospect St.	PRescott 9-0081
PATERSON	Vallario's Pharmacy, 357 Totowa Ave.	ARmory 4-2139
PAULSBORO	Nastese's Pharmacy, 762 Delaware St.	PAulsboro 8-1569
PENNSAUKEN	Thor's Rexall Drugs, 4919 Westfield Ave.	NOrmandy 2-0848
PRINCETON	The Thorne Pharmacy, 168 Nassau St.	WAlnut 4-0077
RAHWAY	Bell Drug Store of Rahway, Inc., 1552 Irving St.	FUlton 1-2000
RAHWAY	Kirstein's Pharmacy, 74 East Cherry St.	FUlton 8-0235

(Continued on following page)

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

(Continued from preceding page)

RIDGEFIELD PARK	Lloyd's Prescriptions, 209 Main St.	Diamond 2-8383
RUMSON	Rumson Pharmacy, W. E. Fogelson	842-1234
SOUTH AMBOY	Madura Pharmacy, 115 N. Broadway	PArkway 1-1732
SOUTH AMBOY	Peterson Pharmacy, 132 No. Broadway	PArkway 1-0137
TRENTON	Adam & Sickles, State & Prospect Sts.	OWen 5-6396
TRENTON	Episcopo's Pharmacy, Chambers & Liberty Sts.	EXport 3-3017
TRENTON	Foy's Drug Store, 3024 So. Broad St.	EXport 3-2367
UNION	Colonial Rexall Pharmacy, 1448 Morris Ave.	MUrdock 7-3100
UNION	Perkins Union Center Pharmacy	MUrdock 6-0877
WEST NEW YORK	Gemignani Pharmacy, 6129 Park Ave.	UNion 5-1296
WEST NEW YORK	The Owl Pharmacy, 6611 Bergenline Ave.	UNion 5-0384
WEST ORANGE	West Orange Pharmacy, 443 Main St.	ORange 4-9824
WRIGHTSTOWN	Bowen's Pharmacy, 152 Fort Dix Road	RAymond 3-2176

FAIR OAKS HOSPITAL

SUMMIT, NEW JERSEY

CRestview 7-0143

OSCAR ROZETT, M.D.
Medical Director

MOLLIE KENNEDY, R.N.
Director, Nursing Service

EDWARD R. DUTY, M.D.
Clinical Director

N. M. JANI, M.D.
S. D. ESTRADA, M.D.
Associate Psychiatrists

THOMAS P. PROUT, JR.,
Administrator

AN 85 BED INTENSIVE TREATMENT PSYCHIATRIC UNIT

Certified by
The Joint Commission on Accreditation of Hospitals
The Central Inspection Board, American Psychiatric Assn.







CLASSIFIED ADVERTISEMENTS

WANTED FOR SALE TO LET
SITUATIONS, ETC.

Send replies to box number c/o The Journal
P. O. Box 904, Trenton 5, N. J.

$3. for 25 words or less; additional words 5c each
Forms close 15th of the preceding Month.

ASSISTANT TO MEDICAL DIRECTOR — For 300 bed county accredited hospital; training or experience in chest diseases and internal medicine (geriatrics) is desirable. Must have New Jersey license. Modern furnished apartment (for single or married persons) and full maintenance at nominal cost; free hospitalization, paid vacation, sick leave and holidays; annual increments. Starting salary, $14,800. Contact Eugene Nargiello, M.D., Superintendent and Medical Director, John E. Runnells Hospital for Chest Diseases, Berkeley Heights, New Jersey.

GENERAL PRACTITIONER—The New Jersey State Colony at New Lisbon, New Jersey, an institution with about 1,200 moderately mentally retarded residents, has an immediate opening for a general practitioner as Senior Physician.

This Colony is located about 10 miles south of Pemberton, 30 miles from Camden, and 30 miles from the seashore on a 1500 acre tract, much of which is farmed by residents. Has a modern 27-bed infirmary, with an additional junior physician, dentists, nurses, and medical attendants. Salary range $10,369 to $13,477 plus insurance, retirement, and other benefits. Thirty-five-hour work week. For information contact Superintendent F. W. Russell at New Lisbon or Dr. J. B. Butler, Department of Institutions and Agencies, 135 West Hanover Street, Trenton.

ANESTHESIOLOGIST—New Jersey licensed, desires position. Write Box 53, c/o The Journal.

OBSTETRICIAN-GYNECOLOGIST—Age 31, Board eligible, university trained, desires association. Write Box 51, c/o The Journal.

YOUNG, WELL-TRAINED PHYSICIAN—To join a busy practice in suburban New Jersey. Beautiful new building now under construction. No investment required. Up to $12,000 for the right man. Early partnership anticipated. Mostly medical and pediatrics. Some obstetrics and ample surgery available. Write now to D. F. GEARING ASSOCIATES, Business Consultants to the Medical Profession, 11 Court Street, White Plains, New York.

MEDICAL PRACTICE FOR SALE—Excellent, long established, due to sudden death. Wonderfully equipped modern offices: X-ray, etc. Beautiful house and garden. Prime location in city in the heart of South Jersey. Rich farm area. Growing population 50,000. Write Box 39, c/o The Journal.

FOR SALE—Immediately available, well established General Practice left by sudden death of physician. Six thousand population town in New Jersey. Wide drawing territory. Area urgently in need of physician. Four hospitals nearby. Six-room modern, air-conditioned, fully equipped office. Contact Mrs. Charles T. Bergen, 438 Main Street, Spotswood, New Jersey. CL 4-3311.

RADIOLOGICAL PRACTICE FOR SALE—Paterson, New Jersey, for the cost of office building, diagnostic, and therapy equipment, lead-lined rooms; 2 tenants' rentals more than enough to cover taxes and other expenses. Reasonable terms. Write Box No. 49, c/o The Journal.

FOR SALE—Retiring doctor's office equipment: General Electric X-ray, 100 Ma., accessories, Wappler short wave, Jone's metabolism, instruments, etc. Reasonable. Irvington. Call ESsex 3-9117.

POSITION WANTED—Medical Assistants and Secretaries. Laboratory and X-ray Techs. Well-trained and highly-qualified personnel (male and female) available. Phone CH 2-2330, Ext. 17, Placement Department, or write Physician Director, Eastern School for Physicians' Aides, Department 7, 85 Fifth Avenue, New York 3, New York.

THE LITERARY FORGE—Port Republic, New Jersey. Save time and energy—send us the rough draft of your medical article or book for finishing. Careful editing and typing. Rewriting for brevity, clarity, and readability. Write for details.

RENT OR SALE—Active general practice in New Jersey shore area. Can introduce. Leaving to specialize. Equipped office and residence. Negotiable terms. Write Box 50, c/o The Journal.

UPPER MONTCLAIR OFFICE TO SHARE—Air-conditioned. Recently occupied by Internist. 500 ma. X-ray, EKG and lab. available. Call PI 4-3636.

FOR RENT—2 suites of offices for medical profession, unequipped. Area needs general practitioner and specialist. Fine residential area on well-traveled routes 202-206. Somerville 1 mile. Contact B. Lewin, 722-6666.

FOR SALE—Paterson, New Jersey. Corner house, ten rooms. Advantageously located. Ideally suited for doctor's office and living quarters. Immediate occupancy. Call 667-0843. Write: O. Edelman, 26 Stockton Place, Nutley, New Jersey.

CLASSIFIED ADVERTISEMENTS

OFFICE FOR RENT—Lake Mohawk, New Jersey. Fully equipped and furnished doctor's office. Includes 3 rooms, lavatory, air-conditioning, heat, water, electric, and a large paved parking lot. Excellent location and fastest growing area in Sussex County offers tremendous possibilities. $250 monthly. Russ Beierle, Inc., Realtor, Sparta, New Jersey. PA 9-6131.

FOR SALE—Modern home and spacious offices on Main Street of county seat in rapidly growing Shore Area. New hospital already enlarging. Furniture and equipment optional. Owner specializing in anesthesiology. Write Box 52, c/o THE JOURNAL.

OFFICE FOR RENT—Irvington. Excellent location, street-level. Occupied by G.P. since 1947. Four large rooms, air-conditioning, reasonable rent with lease. Call evenings ES 2-6712.

PRACTICE AND HOME FOR SALE—Busy young general practitioner retiring to go into full-time research, wishes to sell his $30,000 practice and his beautiful combination home-office in rapidly-growing area in central New Jersey. This is an ideal opportunity for a physician who wants to be busy right away with a beautiful home-office and complete equipment. Write for complete details to: D. F. GEARING ASSOCIATES, Business Consultants to the Medical Profession, 11 Court Street, White Plains, New York.

WOULD YOUR OFFICE RENT STOP . . . IF YOU WERE HOSPITALIZED FOR SIX MONTHS?

Of course not! That's just one of the reasons why wise physicians and dentists take advantage of broad new benefits available in our "Loss of Time" policy.

We pay YOU each month when you are hospitalized or disabled.

For full details, at no obligation, simply send the coupon below.

PHYSICIANS MUTUAL INSURANCE CO.
formerly
Physicians Casualty and Health Associations
"The Doctors Company"
Insuring Physicians & Dentists for 60 years.

Physicians Mutual Insurance Company
115 So. 42nd Street
Omaha 31, Nebraska

Please send details on your "Loss of Time" policy.

NAME_____ AGE_____

ADDRESS_____

CITY_____ STATE_____

The Morristown Rehabilitation Center

66 MORRIS STREET **MORRISTOWN, NEW JERSEY**
JEFFERSON 9-3000



NATHAN KAPLAN, M.D., Physiatrist
MARY E. JOHNSON, Chief Therapist

ANN G. McMANUS, R.N.
Director of Nursing Service

AUDREY E. TAHLMORE
Administrator

A 38-bed rehabilitation unit specializing in orthopedic and neurological disabilities. Speech therapy, Occupational therapy and psychological evaluation available.

AMERICAN HOSPITAL ASSOCIATION ACCREDITATION
MEMBER NEW JERSEY LICENSED NURSING HOME ASSOCIATION

in severe respiratory infections refractory to other measures..

CHLOROMYCETIN®

(chloramphenicol, Parke-Davis)

for established clinical efficacy against susceptible organisms[1-14]



In Friedlander's Pneumonia[3,13]

Although the prognosis in Friedlander's pneumonia is poor, treatment with CHLOROMYCETIN has shown a good response when susceptible strains of *Klebsiella pneumoniae* are incriminated.

In *Hemophilus Influenzae* Pneumonia[3,4,13,14]

Because the invading organism is usually sensitive to CHLOROMYCETIN, this agent is generally effective in pneumonias caused by *H. influenzae*.

In Staphylococcal Pneumonia[1-8,13]

CHLOROMYCETIN continues to remain effective against many resistant strains of staphylococci, and—alone or in combination with other antibiotics—should be considered when other antistaphylococcal drugs are ineffective.

In Acute Epiglottitis[4,10,11]

This condition is most often caused by *H. influenzae,* most strains of which are sensitive to CHLOROMYCETIN. Therapy should be instituted at once, since the disease may progress from the first symptoms to a severe respiratory obstruction in four to six hours.

In Pneumonias Due to Gram-negative Bacilli[9]

Because of its broad-spectrum activity, CHLOROMYCETIN is often effective in pneumonias caused by sensitive strains of *Aerobacter, Proteus* of various species, *Paracolobactrum,* and other gram-negative pathogens encountered with increasing frequency in serious respiratory tract infections.

In Staphylococcal Empyema[12]

The infiltrating lesions of staphylococcal empyema are often difficult to eradicate. While CHLOROMYCETIN should only be used when the infection has been resistant to treatment with other antistaphylococcal drugs, therapy with CHLOROMYCETIN, in conjunction with surgical procedures, will often bring favorable results.

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100. See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections such as colds, influenza, or viral infections of the throat, or as a prophylactic agent.

Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Thacher, H. C., & Fishman, L.: *J. Maine M. A.* **52**:84, 1961. (2) Hopkins, E. W.: *Postgrad. Med.* **29**:451, 1961. (3) Hall, W. H.: *M. Clin. North America* **43**:191, 1959. (4) Krugman, S.: *Pediat. Clin. North America* **8**:1199, 1961. (5) Ede, S.; Davis, G. M., & Holmes, F. H.: *J.A.M.A.* **170**:638, 1959. (6) Wolfsohn, A. W.: *Connecticut Med.* **22**:769, 1958. (7) Calvy, G. L.: *New England J. Med.* **259**:532, 1958. (8) Hendren, W. H., III, & Haggerty, R. J.: *J.A.M.A.* **168**:6, 1958. (9) Cutts, M.: *Rhode Island M. J.* **43**:388, 1960. (10) Berman, W. E., & Holtzman, A. E.: *California Med.* **92**:339, 1960. (11) Vetto, R. R.: *J.A.M.A.* **173**:990, 1960. (12) Sia, C. C. J., & Brainard, S. C.: *Hawaii M. J.* **17**:339, 1958. (13) Rosenthal, I. M.: *GP* **17**:77 (March) 1958. (14) Gaisford, W.: *Brit. M. J.* **1**:230, 1959.

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan

03863

specific for anxiety & tension

Librium

The singular specificity of Librium in controlling anxiety and tension has proven to be an advantage in a wide range of disorders characterized by anxiety of varying degrees. Notably effective in patients whose symptoms are primarily emotional, Librium is equally valuable when organic disease is aggravated or prolonged by accompanying anxiety. Coupled with its effectiveness is an outstanding record of safety. Librium has few, if any, of the unwanted side effects associated with tranquilizers and daytime sedatives—no extrapyramidal effects, no autonomic blocking, and no dulling of mental alertness. Consult literature and dosage information, available on request, before prescribing.

the successor to the tranquilizers

LIBRIUM® Hydrochloride—7-chloro-2-methylamino-5-phenyl-3H-1,4-benzodiazepine 4-oxide hydrochloride



ROCHE

ANNUAL MEETING — MAY 11 - 15, 1963 — HADDON HALL, ATLANTIC CITY

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Entered as second-class matter September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879
Second Class Postage Paid at Orange, N. J.

VOL. 60, NO. 3 MARCH, 1963 Subscriptions, $3.00 per year
Single Copies, 30 Cents

APR 26 1963
LIBRARY

CONTENTS—Pages 99 to 142

EDITORIALS— Page

Medicine's Investment in Blue Shield 99

The Activist Philosophy in Medicine 100

Family Doctor and Mental Health 100

ORIGINAL ARTICLES—

Family Doctor's Responsibility in the Care of the Emotionally Ill Child—Edward P. Duffy, Jr., M.D., Belleville 101

Treatment of Ulcerative Colitis—Eugene P. Salvati, M.D., Plainfield 105

The Camden County Stroke Project—Alvin A. Florin, M.D., South Orange and Aaron M. Rosenthal, M.D., Trenton 109

Methdilazine Intoxication—LeRoy Homer, M.D., Woodbridge 115

Hip Dysplasias in Children—John J. Reilly, M.D., Elizabeth 117

ORIGINAL ARTICLES— Page

Present Status of Stapes Surgery—J. T. Noguera, M.D., Asbury Park and F. Robert Haase, M.D., Neptune 121

Anesthetic Problems in Chest Injury—Joseph A. Cox, M.D. Elizabeth 125

New Frontiers in Psychosomatic Medicine—Jack Chernus, M.D., East Orange 128

STATE ACTIVITIES—

Trustees' Meeting: January 20, 1963 132

CARE and MEDICO 104

Cigarette Smoking 134

Tetanus Immunization 135

LETTERS TO THE JOURNAL 135

ANNOUNCEMENTS 136

OBITUARIES 137

BOOK REVIEWS 138

RESPIRATORY DISEASE ABSTRACTS 141

Roster of Officers, Advertising Page 3 A

Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

Telephone EXport 4-3154



Published Monthly Since 1904

Acceptance for mailing at special rate of postage provided for in Sec. 1103, Act of Oct. 3, 1917, authorized July 29, 1918.

Copyright 1963 by
The Medical Society of New Jersey

The Medical Society of New Jersey Endorsed Plans of

ACCIDENT AND HEALTH INSURANCE
MAJOR MEDICAL EXPENSE INSURANCE
TERM LIFE INSURANCE

****SIX POINT, HIGH LIMIT ACCIDENT INSURANCE**
(Accidental Death, Dismemberment and other Accident Benefits)

Income Protection (Accident and Sickness Insurance)

$1,200 a month new maximum Basic total disability benefit

ACCIDENT: from 1st day, up to 5 years (Partial Accident Disability, half benefit up to six months)
SICKNESS: from 8th day, up to 2 years

$600 a month new maximum Extended total disability benefit, continuing benefits beyond basic coverage.

ACCIDENT: extended to LIFE
SICKNESS: extended through SEVENTH year

Major Medical

$10,000 maximum for Covered Expenses for each accident or sickness, covering member, spouse, and eligible children. $500 deductible, 20% co-insurance.

Life

$10,000 to **$50,000** of Convertible Term Life Insurance.
(Guaranteed exchangeable at any time into Permanent Cash Value life insurance)

Applications for initial $10,000 policy and additional $10,000 policies up to $50,000 total under this plan considered during the month of November each year*.

**** SIX POINT, HIGH LIMIT ACCIDENT INSURANCE**

Up to $200,000 Six Point, High Limit Accident Insurance, covering accidental death, dismemberment, loss of sight, total and permanent disability, exposure and disappearance for member.

Up to $100,000 for spouse (without disability benefit).

Applications are subject to age limits and other company rules and regulations for acceptance of risks. New members have special privileges during the first few months of membership; ask for specific details if you were recently elected and have not received notification from us.

Information and claim service are as close as your telephone.

E. & W. BLANKSTEEN

E. & W. Blanksteen Agency, Inc.

75 MONTGOMERY STREET **JERSEY CITY 2, NEW JERSEY**

DElaware 3-4340

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATON, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.
EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154
(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

OFFICERS

President, Louis S. Wegryn, M.D. ..... Elizabeth
President-Elect, Jerome G. Kaufman, M.D. ..... Maplewood
First Vice-President, Charles H. Calvin, M.D. .. Perth Amboy
Second Vice-President, John J. Bedrick, M.D. ..... Bayonne
Secretary, Marcus H. Greifinger, M.D. ..... Newark
Treasurer, Daniel F. Featherston, M.D. ..... Asbury Park
Mr. Richard I. Nevin, *Executive Officer* ..... Trenton
Mrs. Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton

TRUSTEES

Samuel J. Lloyd, M.D., *Chairman* (1963) ..... Trenton
Nicholas A. Bertha, M.D., *Secretary* (1965) ..... Wharton
Louis S. Wegryn, M.D. ..... Elizabeth
Jerome G. Kaufman, M.D. ..... Maplewood
Charles H. Calvin, M.D. ..... Perth Amboy
John J. Bedrick, M.D. ..... Bayonne
Marcus H. Greifinger, M.D. ..... Newark
Daniel F. Featherston, M.D. ..... Asbury Park
Ralph M. L. Buchanan, M.D. ..... Phillipsburg
Louis F. Albright, M.D. (1964) ..... Spring Lake
Louis K. Collins, M.D. (1964) ..... Glassboro
Thomas C. DeCecio, M.D. (1965) ..... Cliffside Park
Joseph P. Donnelly, M.D. (1963) ..... Jersey City
Lloyd A. Hamilton, M.D. (1965) ..... Lambertville
Frank J. Hughes, M.D. (1963) ..... Gloucester
Joseph R. Jehl, M.D. (1963) ..... Clifton
Emanuel M. Satulsky, M.D. (1964) ..... Elizabeth
Carl N. Ware, M.D. (1965) ..... Ocean City

COUNCILORS

First District (Essex, Morris, Union, and Warren Counties) ..... Henry L. Hermann, M.D., Phillipsburg (1963)
Second District (Bergen, Hudson, Passaic, and Sussex Counties) ..... John L. Olpp, M.D., Englewood (1965)
Third District (Hunterdon, Mercer, Middlesex, and Somerset Counties) ..... Albert F. Moriconi, M.D., Trenton (1964)
Fourth District (Burlington, Camden, Monmouth, and Ocean Counties) ..... E. Vernon Davis, M.D., Moorestown (1963)
Fifth District (Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties).... Isaac N. Patterson, M.D., Westville (1963)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell, M.D. (1964) ..... Asbury Park
William F. Costello, M.D. (1963) ..... Dover
Joseph P. Donnelly, M.D. (1964) ..... Jersey City
Marcus H. Greifinger, M.D. (1964) ..... Newark
Luke A. Mulligan, M.D. (1964) ..... Leonia
Isaac N. Patterson, M.D. (1963) ..... Westville

Alternates

F. Clyde Bowers, M.D. (1964) ..... Mendham
Frank J. Hughes, M.D. (1964) ..... Gloucester
Joseph R. Jehl, M.D. (1964) ..... Clifton
John F. Kustrup, M.D. (1964) ..... Trenton
Elton W. Lance, M.D. (1963) ..... Rahway
John L. Olpp, M.D. (1963) ..... Englewood

DELEGATES TO OTHER STATES

New York—William F. Costello, M.D. (1963) ..... Dover
Connecticut—Lloyd A. Hamilton, M.D. (1963) .. Lambertville
New York—G. Ruffin Stamps, M.D. (1963) .... Atlantic City
Connecticut—S. Eugene Dalton, M.D. (1963) ..... Ventnor

INFORMATION FOR READERS AND CONTRIBUTORS

The Journal is the official organ of The Medical Society of New Jersey, published monthly under the direction of the Committee on Publication. *The Journal* is released on or about the tenth of each month, and a copy is sent to each member of the Society.

Change of Address: Notice of change of address should be sent promptly to The Medical Society of New Jersey, P.O. Box 904, Trenton 5, New Jersey.

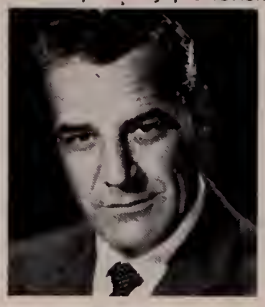
Communications: Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of any material in *The Journal*. All such communications should be directed to the Editorial Office of *The Journal*. The Publication Committee reserves the right to publish, reject, edit or abbreviate all communications submitted to it.

Contributions: Manuscripts submitted to *The Journal* should be typewritten, double-spaced on letter size (about 8¼ by 11 inch) paper and forwarded to the Editorial Office at the address below. The Publication Committee expressly reserves the right to reject any contributions, whether solicited or not; and the right to abbreviate or edit such contributions in conformity with the needs and requirements of *The Journal*. Galley-proofs of edited or abbreviated manuscripts will be submitted to authors for approval before publication. Every care will be taken with the submitted material, but *The Journal* will not hold itself responsible for loss or damage to manuscripts. Authors are required to submit original copies only, and are urged to keep carbon copies for reference. It is understood that material is submitted here for exclusive publication in this *Journal*.

Illustrations: Authors wishing illustrations for their articles will submit glossy prints or original sketches, from which cuts or plates will be made by *The Journal*. The cost of making such cuts will be borne by the author, who will, after publication, receive the cuts for his own use. The cost of these cuts varies with the size and type of the illustration. An estimate of the cost will be submitted to authors before the cuts are ordered.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY
P. O. Box 904, Trenton 5, New Jersey

Photos posed by professional models







more physicians specify



aquasol® A CAPSULES

than any other vitamin A product when indicated in

ACNE dry skin keratosis follicularis ichthyosis pityriasis rubra pilaris night blindness metaplasia of mucous membranes

physically — its microscopically fine aqueous vitamin A particles pass through the intestinal barrier more easily and may reach affected local area more readily through... **faster, more complete absorption**

physiologically — provides all the known physiologically active isomers of the natural vitamin A complex which are believed to be directly utilizable on certain enzymatic processes for... **fully comprehensive results**

gastronomically — with allergenic factors removed and free from "fishy" taste, Aquasol A is... **well tolerated and burpless**

Aquasol A capsules — two potencies: **25,000 U.S.P. units • 50,000 U.S.P. units**
water-solubilized natural vitamin A per capsule — Bottles of 100, 500 and 1000 capsules.

Samples and literature upon request.

u. s. vitamin & pharmaceutical corporation
Arlington-Funk Laboratories, division • 800 Second Ave., New York 17, N. Y.



Relieves Anxiety and Anxious Depression

The outstanding effectiveness and record of safety with which Miltown relieves anxiety and anxious depression—the type of depression in which either tension or nervousness or insomnia is a prominent symptom – has been clinically authenticated time and again during the past seven years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more often than any other tranquilizer in the world.

Miltown®

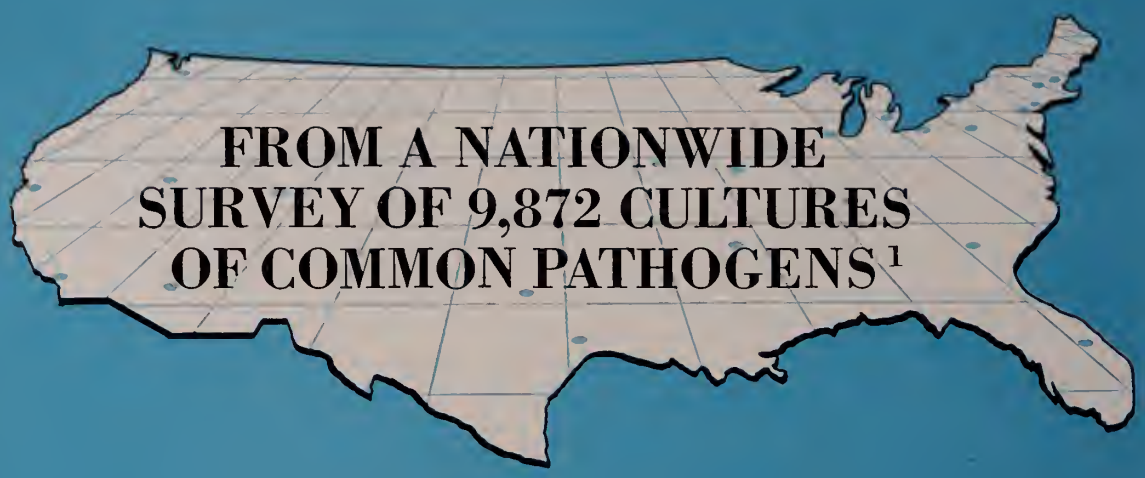
meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS® – 400 mg. *unmarked*, coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

WALLACE LABORATORIES / *Cranbury, N. J.*

Clinically proven in over 750 published studies

1. Acts dependably – without causing ataxia or altering sexual function
2. Does not produce Parkinson-like symptoms or liver damage
3. Does not muddle the mind or impair physical activity



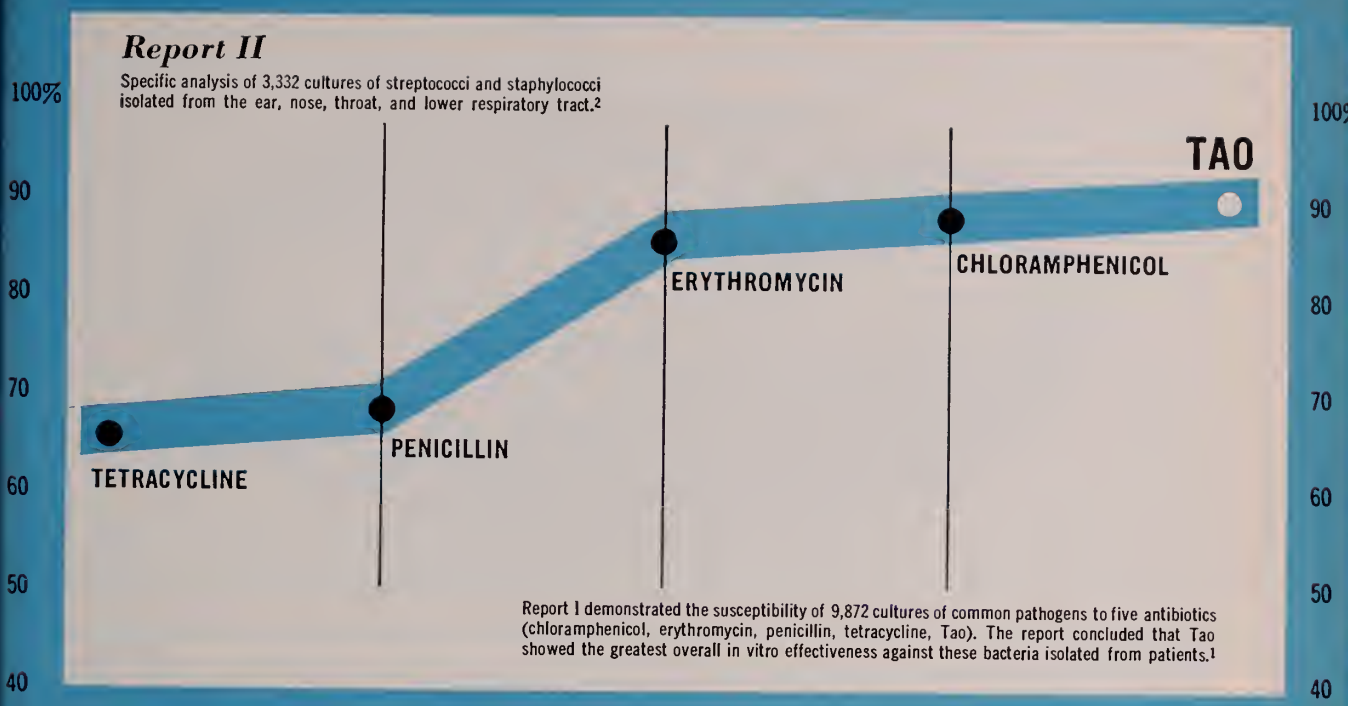
FROM A NATIONWIDE SURVEY OF 9,872 CULTURES OF COMMON PATHOGENS[1]

Conclusions of Nationwide Survey: *Report I*

1. Even after five years of general use, Tao, of the antibiotics tested, demonstrated greatest activity against respiratory streptococci and staphylococci (3,332 cultures).

2. Overall results showed a higher percentage of susceptibility among these common pathogens to Tao than to the other antibiotics. Susceptibility to Tao was greatest, not only in respiratory streptococci and staphylococci, but also in these organisms isolated from skin and soft tissue (3,423 cultures), genitourinary and gastrointestinal tracts and other sources (2,458 cultures). Susceptibility was equal to all antibiotics tested in pneumococci from unspecified sources (463 cultures), and less to Tao in H. influenzae from unspecified sources (196 cultures).

3. Tao has been used for five years without development of predictable cross resistance. In 1958 and 1961, approximately 73% and 70%, respectively, of erythromycin-resistant problem staphylococci showed susceptibility to Tao.[3,4] The present study confirms the continuing high degree of Tao activity even against these pathogens. Of 1,592 cultures of erythromycin-resistant staphylococci, 68% were susceptible to Tao, while in the reverse situation, only 33% of 768 Tao-resistant staphylococci were susceptible to erythromycin.



Report II

Results of Bacterial Susceptibility in 3,332 Respiratory Pathogens

References

1. "Bacterial Susceptibility Patterns: A Geographic Survey." Fowler, J. Ralph, M.D., and Watters, John L., M.D. Scientific Exhibit presented at the Annual Meeting of the American Society of Clinical Pathologists, Chicago, Ill., August 31 to September 9, 1962. 2. Fowler, J. Ralph, Watters, John L. and Levy, Arthur M.: Bacterial Susceptibility Patterns as Related to Geographic Variation and Anatomical Source. In press. 3. English, A. R., and Fink, F. C.: Antibiot. & Chemother. 8:420 (Aug.) 1958. 4. English, A. R., and Fink, F. C.: Antibiot. and Chemother. 11:648 (Oct.) 1961.

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being®

If you would like a report of the entire susceptibility study, write Medical Department, J. B. Roerig and Company, 235 E. 42nd St., New York 17, N.Y.



Capsules · Ready-Mixed Oral Suspension · Pediatric Drops · Parenteral (as oleandomycin phosphate)

mudrane® GG

GLYCERYL GUAIACOLATE LIQUEFIER-EXPECTORANT

A combination of widely used drugs for the treatment of asthma. Each tablet contains *Glyceryl Guaiacolate 100 mg., Aminophylline 130 mg., Ephedrine HCl 16 mg., Phenobarbital 21 mg. . . . compounded for balanced action and buffered for tolerance.

*Glyceryl Guaiacolate has no known side effects.

COMPLETE INFORMATION AND CLINICAL SAMPLES
SENT UPON REQUEST

Dispensed in bottles of 100 and 1000 tablets

WM. P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856



Now! Obtain patient cooperation by...

taking the deprivation out of dieting!

Even 700 calories per day lets patients enjoy delicious meals with MOTT'S FIGURE CONTROL FOODS!

Here is a new kind of diet you can offer patients—familiar, tasty foods of excellent quality, for meals that are a pleasure to eat, yet low in calories, fat and carbohydrates.

The 60 Mott's Figure Control Brand Foods were developed to fit the most broadly-accepted and proven diet concept. They offer a prudent diet, reduced in calories an average of 50%, mostly through the reduction of hard fats (the saturated type), and carbohydrates. A patented non-caloric sweetener is used in the extra-fine quality fruits and desserts, providing satisfying sweetness without extra calories. Natural fruit sugars remain intact.

Patients on low-cholesterol diets may now enjoy low-fat beef dishes, ready to heat and eat. Where additional polyunsaturates are indicated, you may wish to suggest adding polyunsaturated oils to the sauces. Those patients who need drastic calorie reduction in carbohydrates will find it in Figure Control Fruits, Juices, Preserves and Desserts.

Calorie counts as well as carbohydrate, protein and fat proportions of each product appear on its Figure Control label. The wide variety of Figure Control Foods at local supermarkets makes meal planning easy for patients.

MOTT'S FIGURE CONTROL® BRAND FOODS
CUT CALORIES, FAT AND CARBOHYDRATES!

HERE ARE TYPICAL 700 CALORIE PER DAY MENUS

BREAKFAST: Figure Control Breakfast Drink, high in Vitamin C, Farina with Figure Control Preserves or Maplette Syrup, Coffee with Figure Control Sweetener.
Calories—**about 95.** "Regular" food calories would be **about 235.**

LUNCH: Figure Control Fruits with Cottage Cheese, Figure Control French Dressing **or**
Figure Control Chopped Chicken Livers on Rye Bread Slice with Cole Slaw, Figure Control Whipped Dressing.
Black coffee or tea with Figure Control Sweetener.
Calories—**about 220.** "Regular" food calories—**about 400-600.**

DINNER: Shrimp in Figure Control Spaghetti Sauce, Figure Control Chicken a la King **or** Figure Control Braised Beef and Vegetables. Salad with Figure Control Italian Dressing, Figure Control Pears with Figure Control Chocolate Topping. Black coffee or tea with Figure Control Sweetener.
Calories—**about 350.** "Regular" food calories would be **about 720.**

NOTE: For more gradual weight loss, reduce calories daily by substituting two or more Figure Control Foods for "regular" foods in menus.

For your free jar of Figure Control Foods plus easy menu guidance for patients use this handy order form:

FIGURE CONTROL FOODS
Duffy-Mott Company
370 Lexington Avenue
New York 17, New York

Please send free jar of Figure Control Foods together with _____ free copies of Your Weight Control Plan.

Dr._____

Address_____

City_____ Zone___ State_____

Why Sardo®

is the **BATH OIL OF CHOICE** for dry, itchy skin



Why does SARDO so effectively relieve[1-5] dryness and itching in so many patients with eczematoid dermatitis, atopic dermatitis, senile pruritus, contact dermatitis, soap dermatitis, diabetic dry skin, neurodermatitis?

These are the reasons . . .

HIGH QUALITY SARDO is the **original, exclusive,** high quality water-dispersible bath additive oil.*

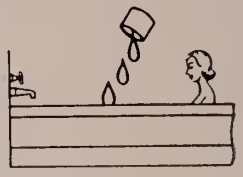
IMMEDIATE DISPERSIBILITY
SARDO promptly disperses millions of microfine globules uniformly throughout the bath water; no unsightly oil slicks as with certain other bath additives.

SUPERIOR ADSORBABILITY SARDO covers the skin with a fine, unobtrusive long-clinging oil film . . . which lubricates, softens, prevents excessive moisture evaporation and so helps to replenish natural oil and moisture.

ECONOMICAL In addition, the cost per application of SARDO is low – for only **one** capful per bath is required for therapeutic effect.

PLEASANT Unique pine scent, non-sticky, non-sensitizing, SARDO assures patient cooperation.

SARDO consists of oils and various esters of specially selected organic acids having a chain length of C-14 and 16 in combination with non-irritating wetting agents to provide colloidal dispersion of the lipophilic phase. Fragrance consists of natural essential oils, isolates, and aromatics.



FOR SAMPLES AND LITERATURE

please write . . . **SARDEAU,** INC. 75 East 55th Street, New York 22, N. Y.

Also available: SARDOETTES, disposable compresses impregnated with SARDO, for topical application in relieving skin dryness, itching, scaliness in the same conditions as listed for SARDO.

1. Borota, A., and Grinell, R. N.: J. Amer. Geriatrics Soc., 10:413, 1962. 2. Spoor, H. J.: N. Y. State J. M., 58:3292, 1958. 3. Lubowe, I. I.: Western Med., 1:45, 1960. 4. Weissberg, G.: Clin. Med., 7:1161, 1960. 5. Lieberman, W.: Amer. J. Proctology, 12:374, 1961.

*Pat. Pend. T.M. c 1963 by Sardeau, Inc.

EVERYBODY DOES IT





Toot! We have a nice little bargain, too...

Accustomed as we are to talking about purity, potency, stability, things like that, we thought you might like to know that mothers can make a nice saving on Vi-Daylin Chewables for the next few weeks. Nothing complicated. She buys a bottle of 100 at the regular price. She gets a bottle of 30 free. Big deal? Well, not a bad one. It means she's getting her Vi-Daylin for less than 3¢ per daily dose per child. You might find some vitamins somewhere that would cost even less. But will the youngsters take them?



These Chewables Taste as Good as They Look

(AND THEY'RE SUGAR-FREE, THANKS TO SUCARYL®)

First cousin to an orange. Next door neighbor to a lemon – that's new VI-DAYLIN® CHEWABLE with *Entrapped* Flavor.

They look like footballs and smell like candy and you've never tasted a chewable vitamin quite like them. What surprises you is not so much what you taste as what you *don't* taste. Vitamins. They simply don't come through – either in taste or aftertaste. Even the riboflavin is trapped and civilized.

Our dual coating process does it – seals the raw vitamin tastes, protects the delicate flavoring agents. Releases the sweet citrus flavor in the mouth, the vitamins in the g-i tract. With *both* vitamins and flavors entrapped, there's just no chance of the tablets turning musty in the bottle.

Rational formula. And sweetened with sugar-free SUCARYL.

If they look good to you, imagine what youngsters will think.

75TH ANNIVERSARY ABBOTT

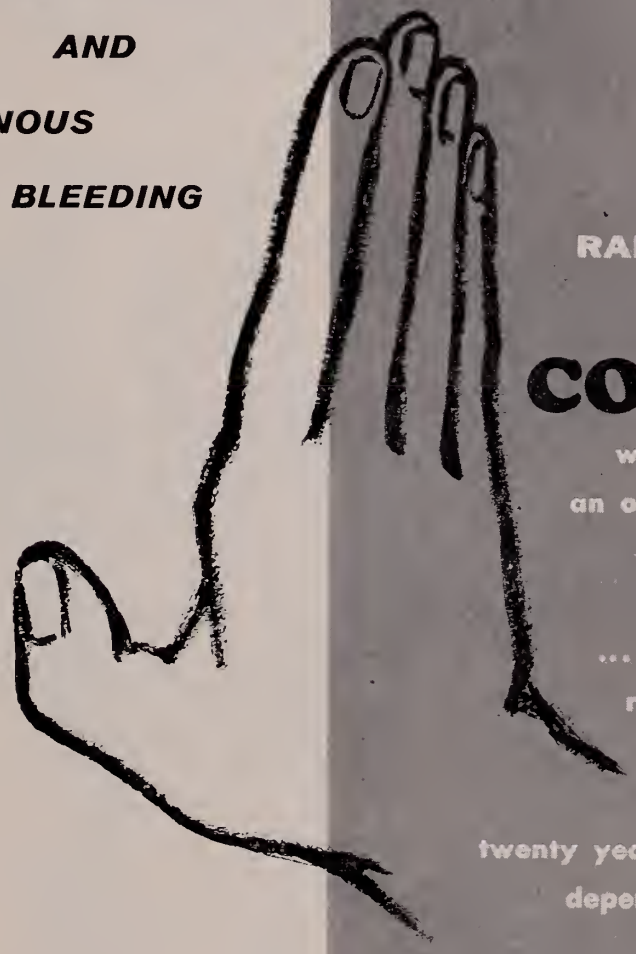


KOAGAMIN®

parenteral hemostat

an aqueous solution of oxalic and malonic acids

FOR CAPILLARY AND VENOUS BLEEDING



RAPID

EFFECTIVE

CONTROL

with an outstanding SAFETY record ...not a single reported adverse effect in over twenty years of continuous dependable service

SUPPLIED IN 10cc MULTIPLE-DOSE VIALS

COMPLETE INFORMATION AVAILABLE ON REQUEST

Chatham

CHATHAM PHARMACEUTICALS, INC. • NEWARK 2, NEW JERSEY

DISTRIBUTED IN CANADA BY AUSTIN LABORATORIES • PARIS, CANADA


SCHWINK

Joint Account

With ARISTOCORT Triamcinolone, patients with rheumatoid arthritis and related disorders of the joints obtain early gratifying relief of pain, swelling, and stiffness of joints, with improved mobility. Yet ARISTOCORT provides symptomatic control with only minimal interference with other metabolic mechanisms. In this respect, ARISTOCORT is unsurpassed, when compared with other corticosteroids, old and new. Typical steroid problems of sodium retention and edema, undesirable euphoria, or voracious appetite and excessive weight gain rarely occur with ARISTOCORT.

Aristocort®
Triamcinolone Lederle

Maximum steroid benefits with minimum steroid penalty

Request complete information on indications, dosage, precautions and contraindications for ARISTOCORT Tablets (1 mg., 2 mg., 4 mg.) from your Lederle representative, or write to Medical Advisory Department.

Lederle LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York
163-3

to bring her back into balance

after menstrual irregularity



an orally active progestogen-estrogen combination

Duosterone®

anhydrohydroxyprogesterone . . . 10.00 mg.
ethinyl estradiol . . . 0.01 mg. } per tablet

Supplementing and supporting ovarian function, DUOSTERONE tablets can help release your patients from the anxiety, discomfort and inconvenience of functional amenorrhea and dysfunctional uterine bleeding.

DUOSTERONE therapy simulates and enhances the normal hormonal pattern of the secretory phase of the menstrual cycle, providing orally potent progesterone with ethinyl estradiol to prime the endometrium for adequate progestational response. Periodic progestational treatment with DUOSTERONE tablets aims at restoring the normal menstrual cycle—much as touching the pendulum starts a tightly wound clock.

Based on the classic studies of Zondek, Rakoff and others, DUOSTERONE provides dependable, trouble-free progestational therapy by mouth.

Bottles of 25 and 100 tablets with complete dosage instructions.

ROUSSEL

Roussel Corporation, New York 17, N.Y.



who coughed?

HYCOMINE® SYRUP for COUGHS

provides fast and long-lasting cough control

relieves cough in 15-20 minutes • lasts 6 hours or longer • promotes expectoration and decongestion of air passages • rarely constipates • agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE Syrup contains:

Hycodan®	6.5 mg.
Dihydrocodeinone Bitartrate	5 mg.
(Warning: May be habit-forming)	
Homatropine Methylbromide	1.5 mg.
Pyrilamine Maleate	12.5 mg.
Phenylephrine Hydrochloride	10 mg.
Ammonium Chloride	60 mg.
Sodium Citrate	85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. On oral prescription where state laws permit. U.S. Pat. 2,630,400.

Literature on request

Endo

ENDO LABORATORIES
Richmond Hill 18, New York

...WITH 'METHEDRINE' SHE CAN HAPPILY REFUSE!



Controls food craving, keeps the reducer happy — In obesity, "our drug of choice has been methedrine . . . because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent." Douglas, H. S.: West.J.Surg. 59:238 (May) 1951.

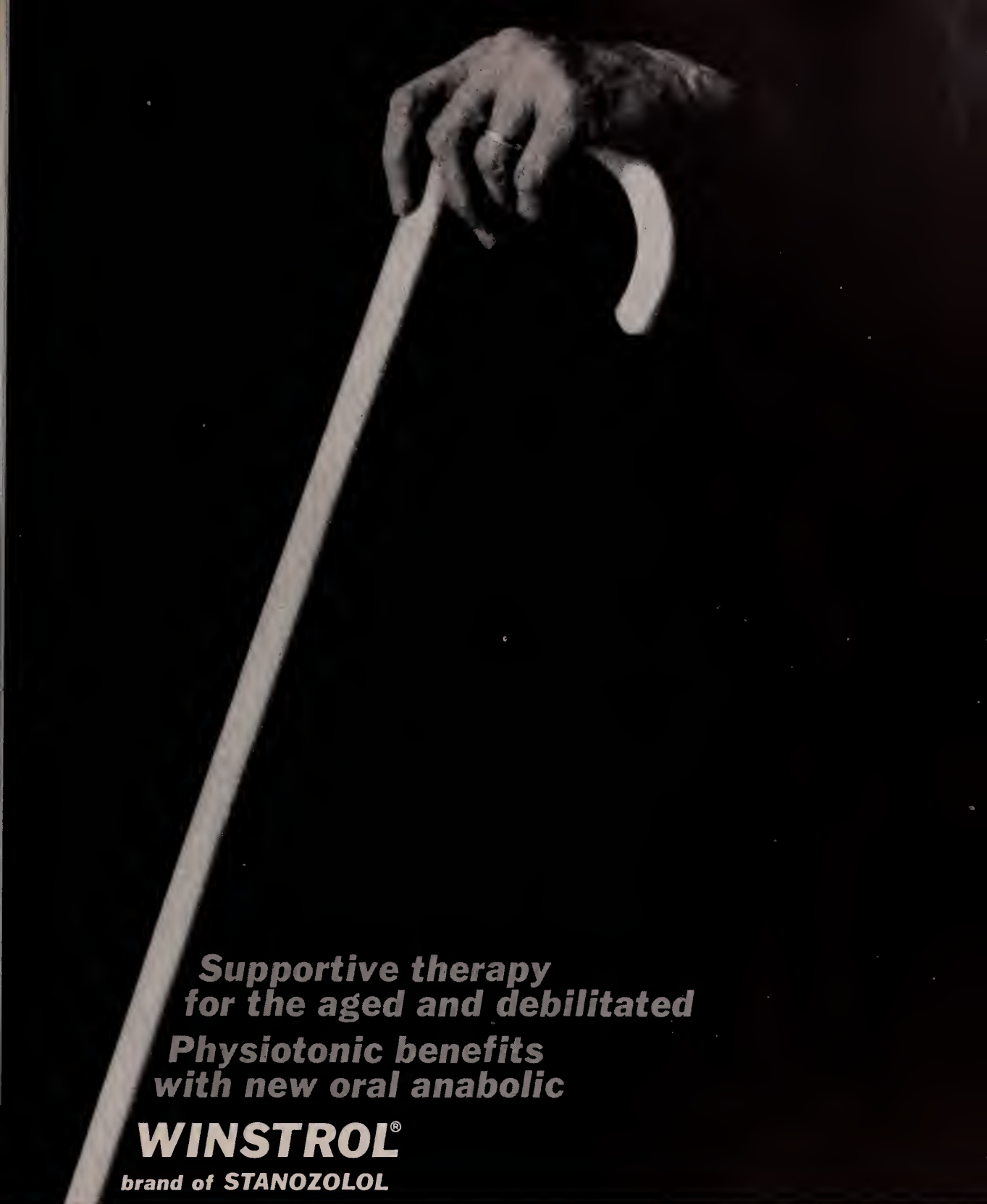
'METHEDRINE'®

brand Methamphetamine Hydrochloride

Supplied: Tablets 5 mg., scored. Bottles of 100 and 1000.

Literature available on request.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York



rked improvement in appetite / Measurable weight gain / Notable increase in vigor, strength and sense of well-bei

w anabolic Winstrol combines highest potency* with outstanding erance in an economical oral tablet. Employed adjunctively, its ysiotonic benefits are evident in the management of a variety of ients: the geriatric; the post-operative; the weak; the debilitated h chronic or malignant disorders. Winstrol reverses tissue-depleting ocesses, restores a positive metabolic balance, rebuilds body tissue ile it builds strength, builds confidence and restores a sense of ll-being.

*ANIMAL DATA

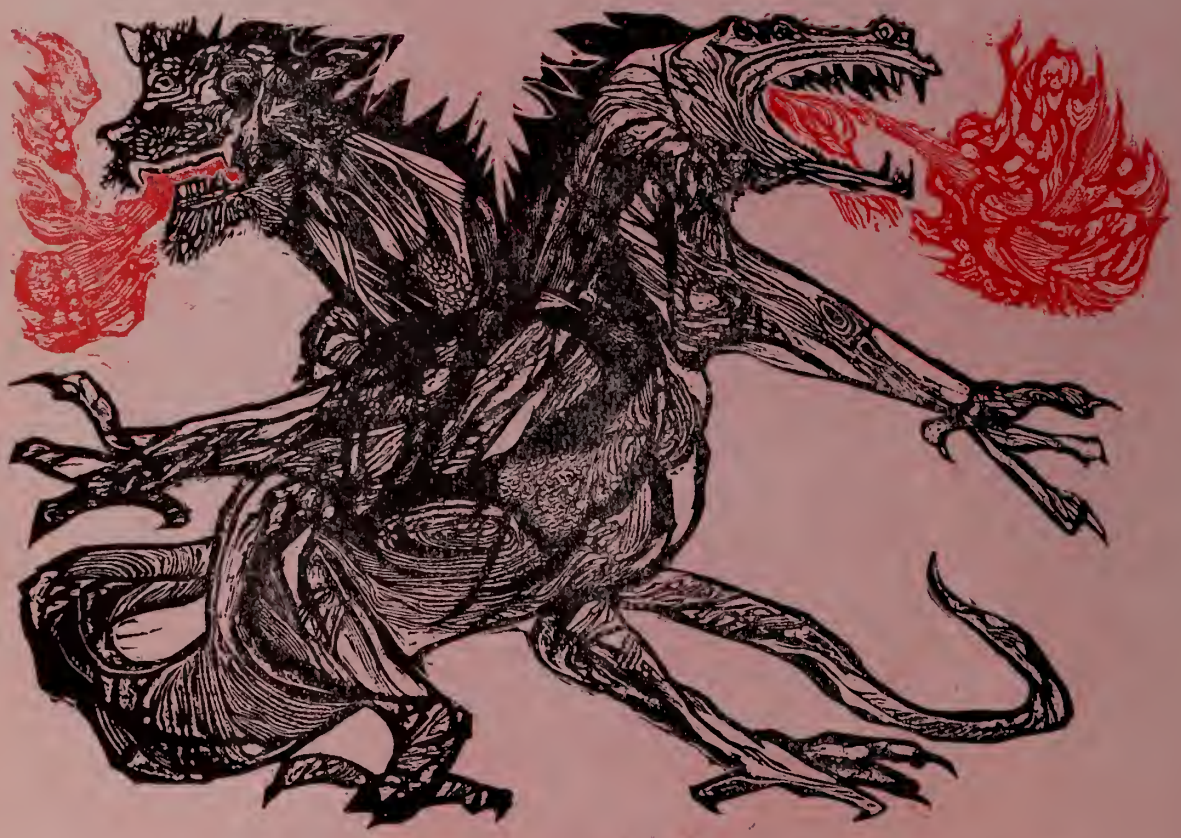
Usual Adult Dose: 1 tablet t.i.d. Before prescribing, consult literature for ad tional dosage information, possible side effects and contraindications.
Supplied: 2 mg. tablets. Bottles of 100.

With Winstrol, patients look better... feel stronger— because they are stronger!

WINTHROP LABORATORIES, NEW YORK 18, N. Y.

Winthrop

When severe pain accompanies skeletal muscle spasm ease both 'pain & spasm'



with **Robaxisal**®

Robins

ROBAXIN® with Aspirin

A dual-acting skeletal muscle relaxant-analgesic, combining the clinically proven relaxant action of ROBAXIN with the time-tested pain relieving action of aspirin.

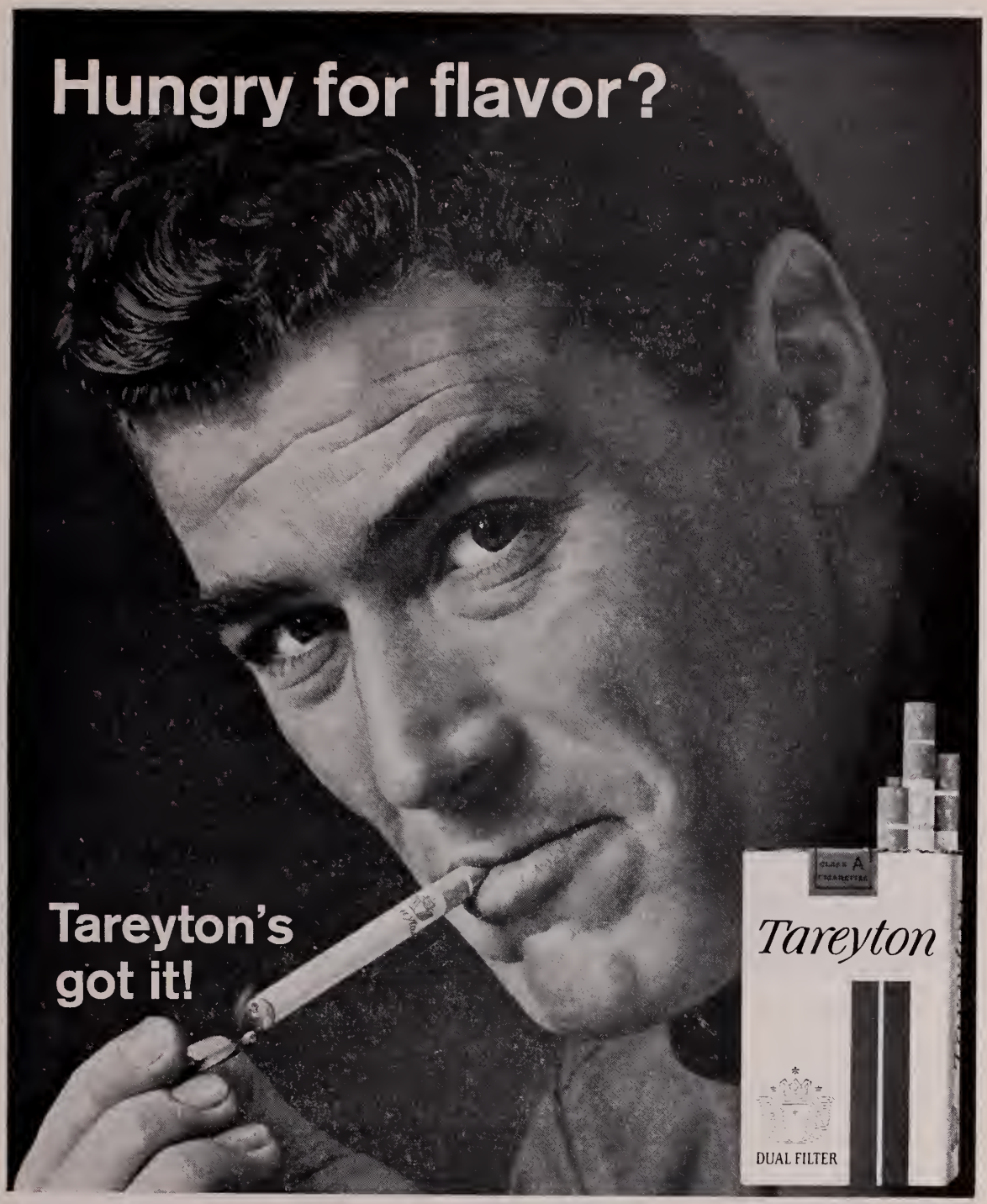
Each ROBAXISAL Tablet contains:
ROBAXIN (methocarbamol Robins) 400 mg. Acetylsalicylic acid (5 gr.)..... 325 mg.
U.S. Pat. No. 2770649
Supply: Bottles of 100 and 500 pink-and-white laminated tablets.

Or ROBAXISAL®-PH (ROBAXIN with Phenaphen®) — when anxiety is associated with painful skeletal muscle spasm.

Each ROBAXISAL-PH Tablet contains:
ROBAXIN (methocarbamol Robins) 400 mg. Acetylsalicylic acid ..... 81 mg.
Phenacetin 97 mg. Hyoscyamine sulfate 0.016 mg. Phenobarbital (1/8 gr.) 8.1 mg.
Supply: Bottles of 100 and 500 green-and-white laminated tablets.

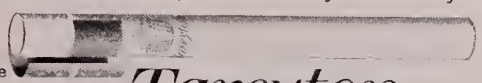
A. H. ROBINS CO., INC., Richmond 20, Virginia

Making today's medicines with integrity . . . seeking tomorrow's with persistence.



Flavor you never thought you'd get from any filter cigarette!

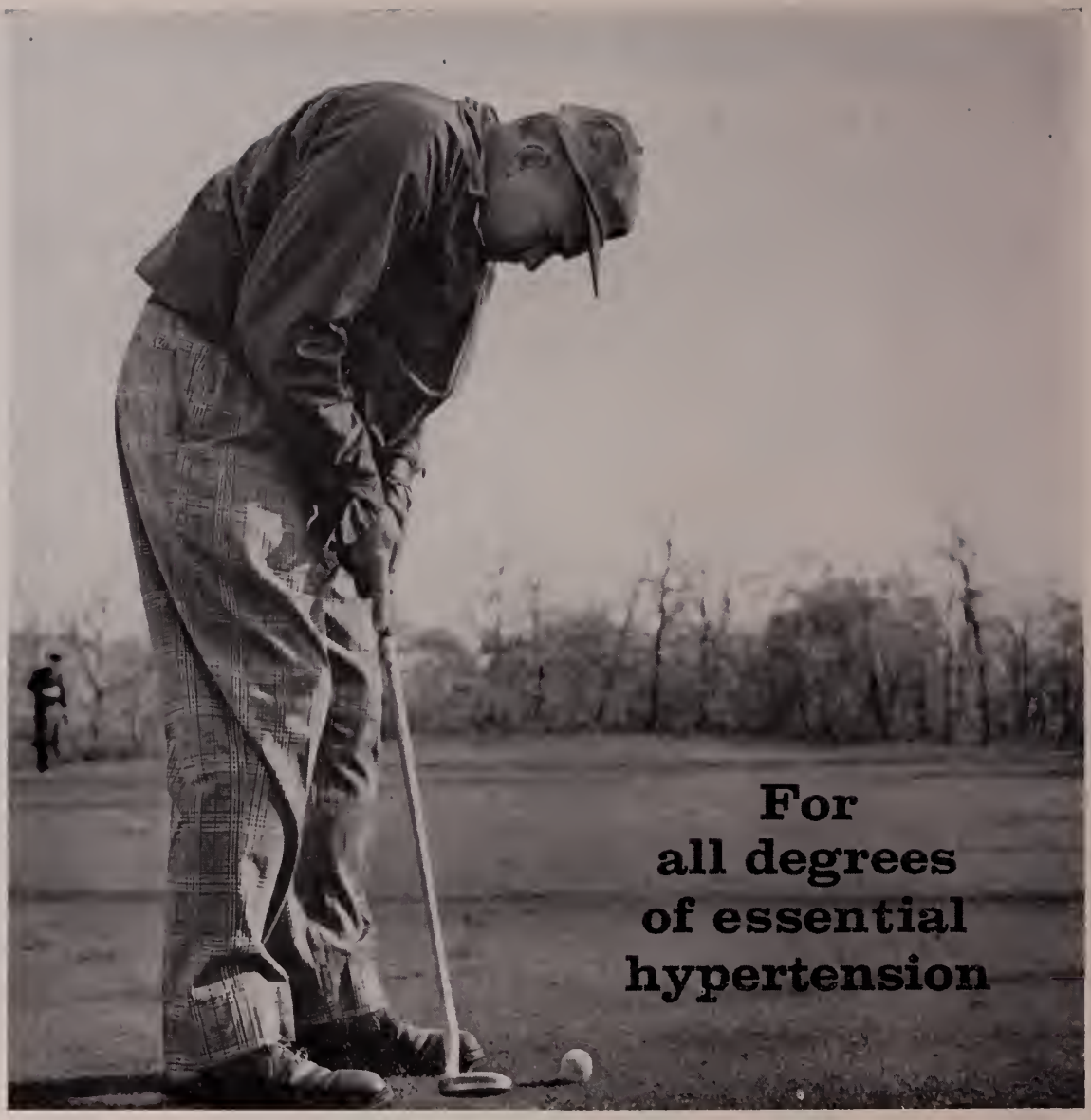
You'll never know how satisfying filter smoking can be until you try Tareytons. Fine, flavor-rich tobaccos go into each Tareyton. Then the famous Dual Filter brings out the best taste of these choice tobaccos. Sound too good to be true? Pick up a pack of Tareytons today and see for yourself.



Dual Filter makes the difference

DUAL FILTER Tareyton

Product of The American Tobacco Company — Tobacco is our middle name



"relief of symptoms is striking with Rautrax-N"†

Rautrax-N decreases blood pressure for almost all patients with mild, moderate or severe essential hypertension. Rautrax-N also offers a new sense of relaxation and well-being in hypertension complicated by anxiety and tension. And in essential hypertension with edema and/or congestive heart failure, Rautrax-N achieves diuresis of sodium and chloride with minimal effects on potassium and other electrolytes.

Rautrax-N combines Raudixin (antihypertensive-tranquilizer) with Naturetin c̄ K (antihypertensive-diuretic) for greater antihypertensive effect and greater effectiveness in relief of hypertensive symptoms than produced by either component alone. Rautrax-N is also flexible (may be prescribed in place of Raudixin or Naturetin c̄ K) and economical (only 1 or 2 tablets for maintenance in most patients).

Supply: Rautrax-N — capsule-shaped tablets providing 50 mg. Raudixin, 4 mg. Naturetin and 400 mg. potassium chloride. *Rautrax-N Modified* — capsule-shaped tablets providing 50 mg. Raudixin, 2 mg. Naturetin and 400 mg. potassium chloride.

†Hutchison J. C.: Current Therap. Res. 2:487 (Oct.) 1960.

For full information, see your Squibb Product Reference or Product Brief.

Rautrax-N*

Squibb Standardized Rauwolfia Serpentina Whole Root (Raudixin) and Bendroflumethiazide (*Naturetin) with Potassium Chloride

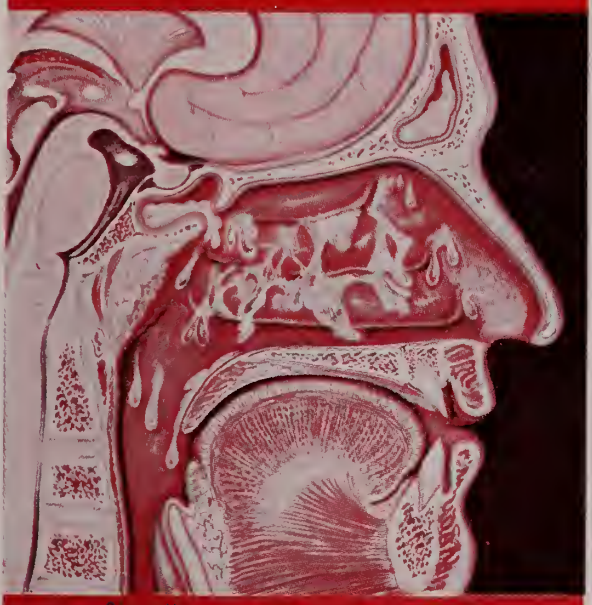
SQUIBB *Squibb Quality — the Priceless Ingredient*

SQUIBB DIVISION Olin

'RAUDIXIN'®, 'RAUTRAX'®, AND 'NATURETIN'® ARE SQUIBB TRADEMARKS.

indication:

respiratory tract disorder



Sinusitis

indicated:

Chymoral®

ORAL systemic anti-inflammatory enzyme tablet

80% Excellent/Good Results in 4,491 Cases[1-4]

Chymoral exerts a favorable influence in many respiratory tract disorders. It reduces inflammation and swelling of nasal and sinusal mucosa, relieves engorgement of nasal turbinates, encourages free drainage.[2,3] Patients experience less discomfort as accumulation of secretions is reduced and airflow improves.[1,4]

Condition	No. of Cases	Excellent/Good	Fair	Poor
Sinusitis	1,588	1,303	190	95
Rhinitis	514	413	61	40
Bronchitis	1,312	1,087	158	67
Bronchial Asthma	1,077	824	175	78
Totals	4,491	3,627	584	280

reduces respiratory inflammation, edema and discomfort

1. Taub, S. J.: Clin. Med. 7:2575, 1960. 2. Physicians' Reports to the Medical Department, Armour Pharmaceutical Company, 1961. 3. Billow, B. W., *et al.*: Southwestern Med. *41*:286, 1960. 4. Teitel, L. H., *et al.*: Indust. Med. *29*:150, 1960.

CHYMORAL is an ORAL anti-inflammatory enzyme tablet specifically formulated for intestinal absorption. Each tablet provides enzymatic activity, equivalent to 50,000 Armour Units, supplied by a purified concentrate which has specific trypsin and chymotrypsin activity in a ratio of approximately six to one. ACTION: Reduces inflammation of all types; reduces and prevents edema except that of cardiac or renal origin; hastens absorption of blood and lymph extravasates; helps to liquefy thick tenacious mucous secretions; improves regional circulation; promotes healing; reduces pain. INDICATIONS: Chymoral is indicated in respiratory conditions such as asthma, bronchitis, rhinitis, sinusitis; in accidental trauma to speed absorption of hematoma, bruises, and contusions; in inflammatory dermatoses to ameliorate acute inflammation in conjunction with standard therapies; in gynecologic conditions such as pelvic inflammatory disease and mastitis; in obstetrics as episiotomies and breast engorgement; in surgical procedures as biopsies, hernia repairs, hemorrhoidectomies, mammectomies, phlebitis and thrombophlebitis; in genitourinary disorders as epididymitis, orchitis and prostatitis; in dental and oral surgery as fractures of the mandible or maxilla, difficult or multiple extractions, and alveolectomies. CONTRAINDICATIONS: None known. INCOMPATIBILITIES: None known. Antibiotics as well as generally accepted measures may be coadministered. SIDE EFFECTS: Mild gastric upsets, rarely encountered. DOSAGE: Recommended initial dose is two tablets q.i.d.; one tablet q.i.d. for maintenance. SUPPLIED: Bottles of 48 and 250 tablets. Issue: Rev. October, 1962

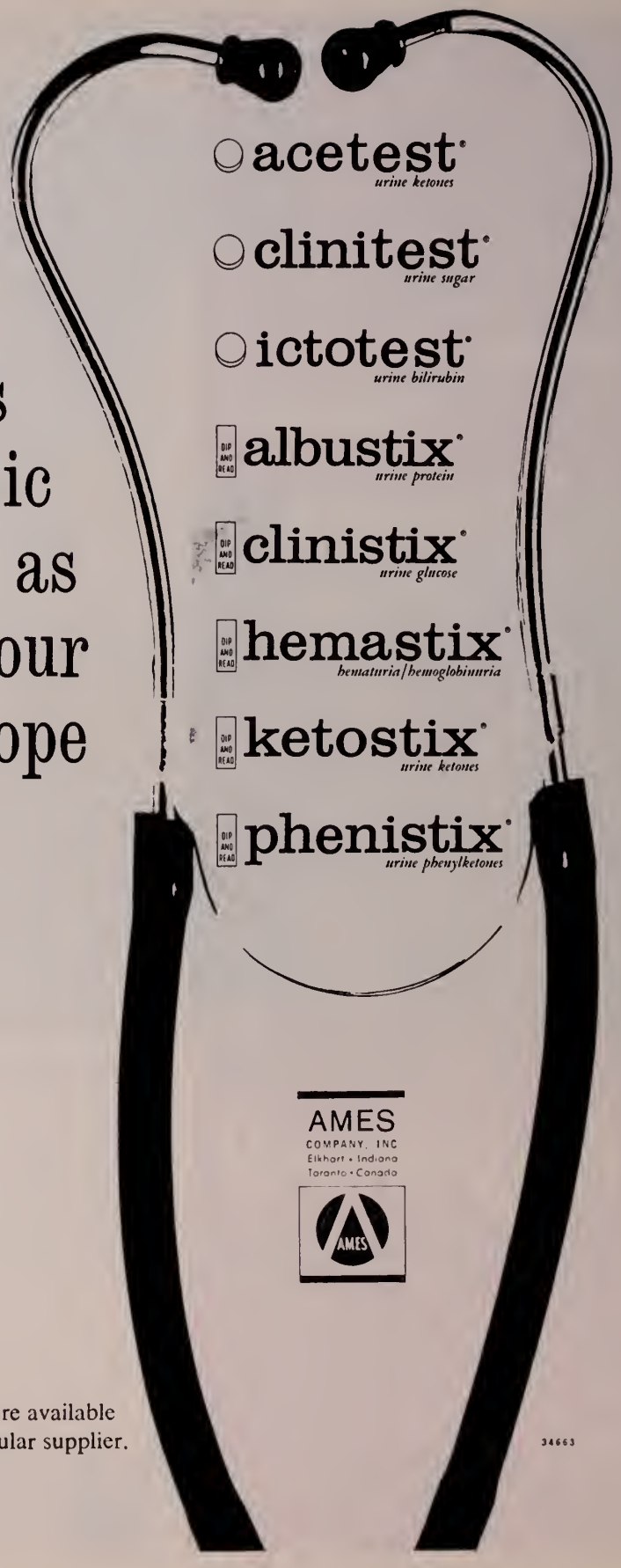
The true economy of proven effective dosage

ARMOUR PHARMACEUTICAL COMPANY

KANKAKEE, ILLINOIS

Originators of Listica®

urine tests as basic as your stethoscope



- acetest® — *urine ketones*
- clinitest® — *urine sugar*
- ictotest® — *urine bilirubin*
- DIP AND READ albustix® — *urine protein*
- DIP AND READ clinistix® — *urine glucose*
- DIP AND READ hemastix® — *hematuria/hemoglobinuria*
- DIP AND READ ketostix® — *urine ketones*
- DIP AND READ phenistix® — *urine phenylketones*

AMES
COMPANY, INC
Elkhart • Indiana
Toronto • Canada

AMES products are available through your regular supplier.

34663



Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

> Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. USUAL DOSAGE: 1 TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey



POSED BY MODELS



all things considered

in bronchitis—Considering the pattern of mixed bacteria, localized or diffu involvement, potential underlying disease, and the need to allay symptoms and ea respiratory/cardiac function... physicians often include DECLOMYCIN demethylchlo tetracycline in the course of therapy.

DECLOMYCIN produces activity levels higher than those of other tetracyclines... at low dosage... and maintains them during the entire course of treatment without significa fluctuation.

This activity is prolonged 24 to 48 hours after the last dose, helping to protect against relaps

Over the wide range of everyday infections—respiratory, urinary and most others—in th young and the aged—the acutely or chronically afflicted—DECLOMYCIN provides th "extra dimension" in broad spectrum control.

the decision is for

For *adults: Capsules*, 150 mg. and 75 mg. For *children:* cherry-flavored *Pediatric Drops*, 60 mg./cc., and cherry-flavor *Syrup*, 75 mg./5 cc. Request complete information on indications, dosage, precautions and contraindications from yo Lederle representative, or write to Medical Advisory Department.

ECLOMYCIN

DEMETHYLCHLORTETRACYCLINE LEDERL

LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY • Pearl River, N. Y.

Lederle





Day and night– less wheezing, coughing, labored respiration in chronic bronchitis and emphysema

New Isuprel Compound Elixir is a balanced expectorant bronchodilator. It contains potassium iodide to promote expectoration and relieve dry cough. Its three bronchodilators, Isuprel, ephedrine, and theophylline, keep bronchi continuously dilated. Luminal is included to negate possible side effect from adrenergic medication and to provide very mild sedation for the patient.

New Isuprel Compound Elixir alleviates symptoms...prolongs relief in chronic bronchitis and emphysema.

Each good-tasting vanilla-flavored tablespoon (15 cc.) contains:

Isuprel® (brand of isoproterenol) HCl	2.5 mg.
Ephedrine sulfate	12 mg.
Theophylline	45 mg.
Potassium iodide	150 mg.
Luminal® (brand of phenobarbital)	6 mg.
Alcohol	19%

Adult Dose: 2 tablespoons 3 or 4 times daily.

How Supplied: Isuprel Compound Elixir is supplied in bottles of 16 fl. oz.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

New ISUPREL® compound ELIXIR

Winthrop LABORATORIES
New York 18, N.Y.

ISUPREL AND LUMINAL, TRADEMARKS REG. U. S. PAT. OFF.



Older people become weak and dispirited

New Dianarit-B helps them get going again

Dianarit-B is a unique new formula designed to help you deal with weakness, poor appetite, fatigue, and lethargy in older people.

Dianarit-B provides Dianabol® to make older people feel stronger. Dianabol helps them regain appetite, strength and vigor; take better care of themselves and their homes; share in activities of families and friends.

Dianarit-B provides Ritalin® to make older people feel more alive. Ritalin brightens mood and improves physical performance; spirits revive, optimism returns; patients have fresh energy and drive to meet each new day.

Dianarit-B also supplies B-vitamins and calcium for nutritional support.

SUPPLIED: *DIANARIT-B Capsules, each containing 1.25 mg. DIANABOL® (methandrostenolone CIBA), 5 mg. RITALIN® hydrochloride (methylphenidate hydrochloride CIBA), 5 mg. vitamin B_1, 1 mg. vitamin B_2, 2 mg. vitamin B_6, 2 mcg. vitamin B_{12} activity, 25 mg. nicotinamide, and 250 mg. dicalcium phosphate.*

For complete information about Dianarit-B (including dosage, cautions, and side effects), write CIBA, Summit, N. J. 2/3080MB

CIBA

Dianarit-B T.M.

"The first prescription I ever wrote was for 'Empirin' with Codeine...



and it is still my stand-by for pain relief today."

PICTURE THE YOUNG DOCTOR with his first private patient, about thirty-five years ago. This is the moment, after years of study and guidance in classroom and at hospital bedside, when he assumes the full weight of responsibility for the well-being of his patient. He makes his diagnosis. The patient is in considerable pain, and his first concern is to relieve this discomfort. He writes a prescription for a new analgesic, a convenient drug combination that he believes will be of help. This patient (and many others to follow) finds gratifying relief, and the physician continues to rely upon this medication as the years go by.

Could this have been you in the 1920's? That was when 'Empirin' Compound with Codeine first came into general use (although plain 'Empirin' Compound has been well-known since the influenza epidemic of 1918). Satisfaction through the years has prompted doctors everywhere to depend on 'Empirin' with Codeine for relief of most all degrees of pain. For with this well-tolerated, reliable analgesic combination you can be sure of results, and feel secure in the fact that the liability of addiction is negligible.

Please accept our thanks for continuing to place your trust in a product that has been used more widely in medicine each year for the past four decades.

'EMPIRIN' COMPOUND with CODEINE PHOSPHATE*

Acetophenetidin, gr. 2½
Acetylsalicylic Acid, gr. 3½
Caffeine, gr. ½

Remember there are now four strengths available...

*Warning—May be habit-forming.
Subject to Federal Narcotic Regulations.

No. 1 — gr. ⅛
No. 2 — gr. ¼
No. 3 — gr. ½
No. 4 — gr. 1

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

SENIOR CITIZENS



FULFILLING A RESPONSIBILITY VOLUNTARILY

THE BLUE SHIELD NATIONAL SENIOR CITIZEN PROGRAM has become a reality in New Jersey — thanks in large part to the cooperation and support of The Medical Society of New Jersey.

In endorsing the program, and the formula establishing lower Blue Shield fees for services rendered elderly persons of modest means, the Society struck a strong blow for the preservation of the voluntary system of medical practice. But the battle is not yet won.

For the Senior Citizen Program to prove that the voluntary system can indeed carry this burden will require unremitting effort by the profession in partnership with the Plan, not without some sacrifice. Medical-Surgical Plan knows that it will continue to receive this whole-hearted support from the profession — and for its part, is proud to provide the vehicle through which organized medicine registers its willingness to continue helping the less fortunate — voluntarily!

BLUE SHIELD®
for Doctor Bills

Medical-Surgical Plan of New Jersey



after surgery: vitamins are therapy

Nutritional supplementation is basic to postoperative care. Therapeutic allowances of B and C vitamins help meet increased metabolic requirements and compensate for stress depletion. STRESSCAPS can set the patient on a more favorable course and contribute to full recovery. Packaged in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

STRESSCAPS®

Stress Formula Vitamins Lederle



from tabardilho in Brazil to acute bronchitis in New Jersey

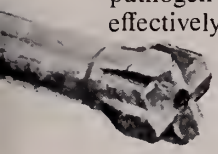
there is a world of experience behind **Terramycin®**

BRAND OF OXYTETRACYCLINE

Whether treating *tabardilho* or a host of other infections, physicians throughout the world continue to rely on TERRAMYCIN for its outstanding safety, effectiveness and excellent tolerability. Not a single case of phototoxic reaction, blood dyscrasia or neurologic disturbance directly attributable to TERRAMYCIN has been reported in more than 3,000 clinical papers in the last 12 years. *In your practice, the next infection you see will very likely be "Terra-responsive."*

Tabardilho, a type of tick typhus, is probably an analog of Rocky Mountain spotted fever, and is caused by *Rickettsia rickettsii.* The tick vectors are any of several species of amblyomma.* The natural reservoirs are the opossum, dogs, the wild rabbit, and the agouti,* a rodent about the size of a rabbit. Mortality is reported to run as high as 80%.

Usually, a lesion is found at the bite site with accompanying regional lymphadenitis.* Actual onset is abrupt with severe headache, arthralgias, myalgias, prostration, extremely high fever, and a marked leukocytosis. A distinctive rash appears about the fourth febrile day; discolorations may persist for several weeks during convalescence. The pathogen grows readily in the yolk sac of the developing chick embryo.* *Tabardilho* is effectively treated by TERRAMYCIN. **illustrated*



IN BRIEF The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. For complete information on Terramycin dosage, administration, and precautions, consult package insert before using. *More detailed professional information available on request.*

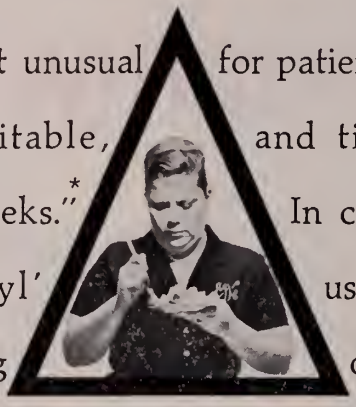
Science for the world's well-being®

Pfizer

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc.
New York 17, New York



WHAT IS SO IMPORTANT ABOUT THE MOOD-ELEVATING EFFECT OF DEXAMYL® IN OVERWEIGHT?



"It is not unusual for patients on a low-calorie diet to feel low, irritable, and tired during the first two or three weeks."* In contrast, the dieting patient on 'Dexamyl' usually gains a brighter outlook, a feeling of energy and general well-being, and, most important, confidence that she really can lose weight after all! In addition to its mood effect, one 'Dexamyl' Spansule® sustained release capsule taken in the morning effectively curbs appetite all day—both at and between meals.



*Matlin, E.: *The Obvious in Obesity, Clin. Med.* 8:1071 (June) 1961.*

FORMULA: Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine® (brand of dextro amphetamine sulfate) and 1½ gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 1 contains 10 mg. of 'Dexedrine' (brand of dextro amphetamine sulfate) and 1 gr. of amobarbital [Warning, may be habit forming]. The active ingredients of the 'Spansule' capsule are so prepared that a therapeutic dose is released promptly and the remaining medication, released gradually and without interruption, sustains the effect for 10 to 12 hours.

INDICATIONS: (1) For control of appetite in overweight; (2) for mood elevation in depressive states.

USUAL DOSAGE: One 'Dexamyl' *Spansule* capsule taken in the morning for 10- to 12-hour therapeutic effect.

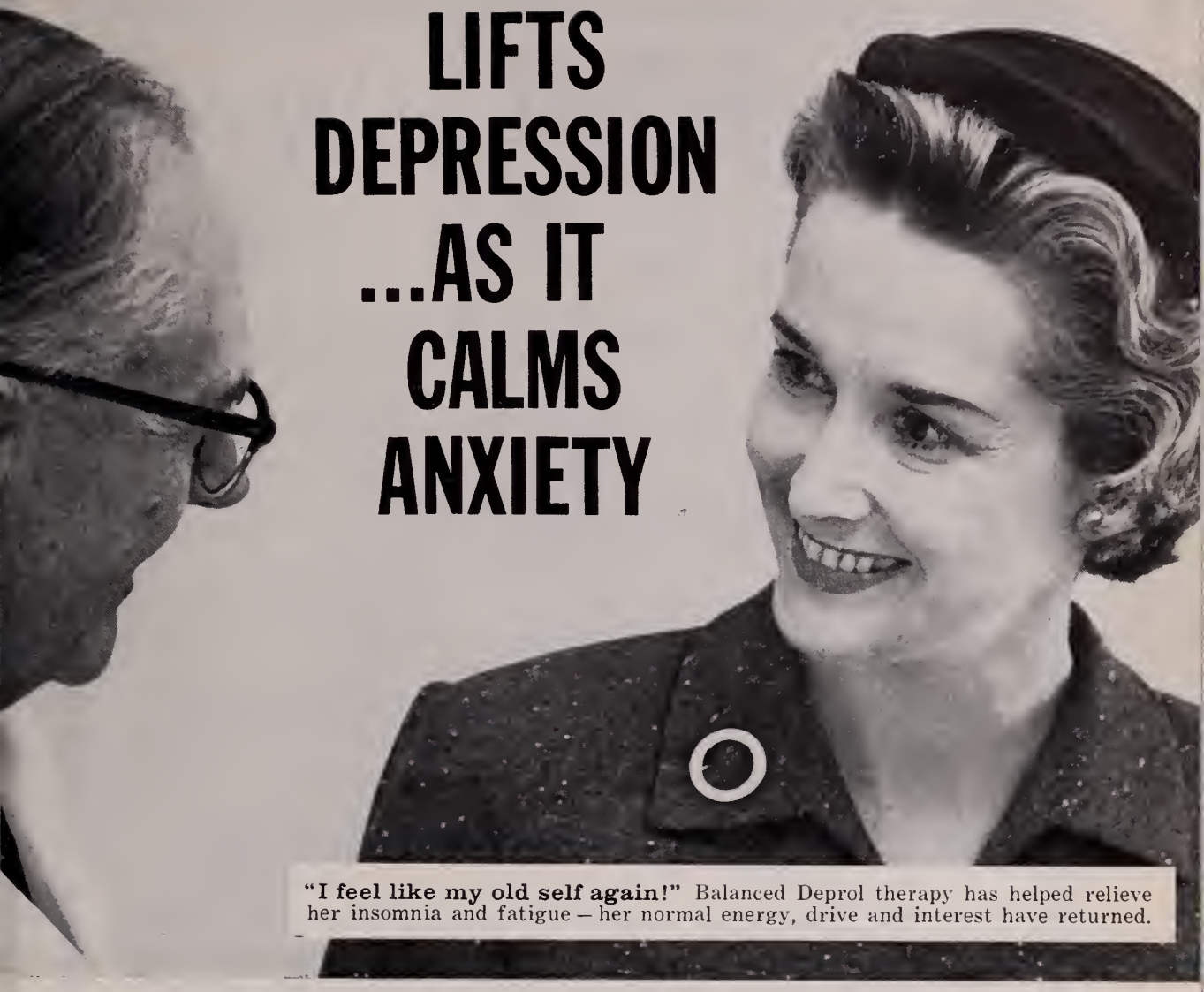
SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

CAUTIONS: Use with caution in patients hypersensitive to sympathomimetic compounds or barbiturates and in coronary or cardiovascular disease or severe hypertension.

SUPPLIED: Bottles of 50 capsules.

Smith Kline & French Laboratories SK&F *Prescribing information October 1962*

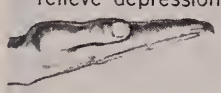
LIFTS DEPRESSION ...AS IT CALMS ANXIETY



"I feel like my old self again!" Balanced Deprol therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

Brightens mood...relaxes tension

Energizers relieve depression





Deprol both lifts depression and calms anxiety





Tranquilizers reduce anxiety

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be increased gradually up to 3 tablets q.i.d. With establishment of relief, the dose may be reduced gradually to maintenance levels.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets.

Write for literature and samples.

▲Deprol▲®

WALLACE LABORATORIES
Cranbury, N. J.

CD-7393

PROFESSIONAL LIABILITY INSURANCE PROGRAM

officially endorsed by

THE MEDICAL SOCIETY OF NEW JERSEY

PROTECTION for Professional Acts and Professional Premises Liability for members of The Medical Society of New Jersey by the First American Liability Insurance Company.

LOSS CONTROL. Your County Medical Review and Advisory Committee will evaluate malpractice cases and recommend the action which would be most favorable for the Medical Profession, the Defendant Doctor, the Patient and the Public. This program permits understanding of the complex problems involved in such cases and calls for close cooperation between the Medical Profession and Insurance Company.

MEDICO-LEGAL FORMS are furnished to each insured doctor to help in reducing claims or dissatisfied patients. Failure to use forms does not affect the doctor's insurance coverage or his eligibility for insurance.

INSURANCE COUNSELING. Insurance counseling and advice, available at all times, without cost, to help you with your Professional Liability insurance problems.

CANCELLATION. No policy will be cancelled or non-renewed without prior consultation between your Society and the Company and this is a matter of complete cooperation for the best interests of all concerned.

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY

Policies Guaranteed Non-assessable

Professional Liability Department

123 CLEVELAND STREET — ORANGE, NEW JERSEY

Joseph A. Britton, Manager — ORange 3-2575

Home Office: Wakefield, Mass.

Milestones in Nutrition

1881 when something was missing...

. . . they turned to milk. In 1881 Lunin showed that mice died when fed a diet consisting of carbohydrate, protein, fat and minerals. Fresh milk saved their lives . . . and the existence of what we now call vitamins was demonstrated.

Historically, milk has been one of the first choices of scientists when they needed a likely source of missing nutrients. And milk has usually filled the need . . . at one time because it contained vitamin A . . . at another, vitamin D . . . and, at others, B vitamins or protein.

Today, dairy products continue to be an important source of many nutrients. When consumed as part of an adequate diet, they provide:

. . . ⅔ of the calcium
. . . ½ of the riboflavin
. . . ¼ of the protein

. . . required by adults . . . plus significant amounts of vitamins A, D and the B complex. In weight control diets low calorie dairy foods are unsurpassed as sources of essential nutrients.

As they have in the past, milk and other dairy foods will continue to play a vital role in the nutritional welfare of our people.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.



Since 1915 . . . promoting better health through nutrition research and education

NATIONAL DAIRY COUNCIL
a non-profit organization
202 EAST 44TH STREET · NEW YORK 17, NEW YORK

AVAILABLE ON REQUEST: Reprints of this series of messages on "MILESTONES IN NUTRITION" and "CALORIE RESTRICTED DIETS"



Deltasmyl®

gives safer steroid protection from asthma

The aim of therapy in asthma should be relief of bronchospasm by means of decongestant and bronchodilating agents *plus prednisone*. When long-continued prednisone treatment is desirable, "the use of bronchodilator medication and other allied drugs should be continued *in order to decrease the dosage of the steroid hormone to a minimum*." (Barach, A. L. and Bickerman, H. A.: Pulmonary Emphysema, Baltimore, The Williams and Wilkins Company 1956, p. 523.)

One DELTASMYL tablet provides the smallest, safest dose of prednisone (1.5 mg.), augmented by theophylline (120 mg.), ephedrine HCl (15 mg.), and phenobarbital (8 mg.), protects against asthma for about 4 hours. Not more than six tablets should be taken in 24 hours. Bottles of 50 tablets.

ROUSSEL — **Roussel Corporation,** 155 East 44th St., New York 17

advancing or complicated hypertension responds to

new Naquival®

brand of trichlormethiazide and reserpine

with STEP-BY-STEP reduction (no sudden drops[1-4]) of elevated blood pressure ☐ relief of associated headache,[3,4] dizziness,[2-4] edema,[2-5] anxiety and tension[1] ☐ simplified dosage (twice daily)...long-term economy

(With new NAQUIVAL there are no reported toxic effects,[2-5] side effects are minor and infrequent,[1-5] and salt restriction[1,5] or added potassium[1] is rarely needed.)

Supplied: NAQUIVAL Tablets, containing 4 mg. trichlormethiazide and 0.1 mg. reserpine, bottles of 100.

References: (1) Ernst, E. M.: Current Therap. Res. **3**:167, 1961. (2) Starling, R. J.: J.M.A. Georgia **50**:442, 1961. (3) Sprogis, G. R.: Current Therap. Res. **3**:393, 1961. (4) Coffee, H. L.: Clin. Med. **69**:1561, 1962. (5) Mattey, W. E.: Indust. Med. **31**:33, 1962.

Schering

mild or moderate hypertension responds to

Naqua®

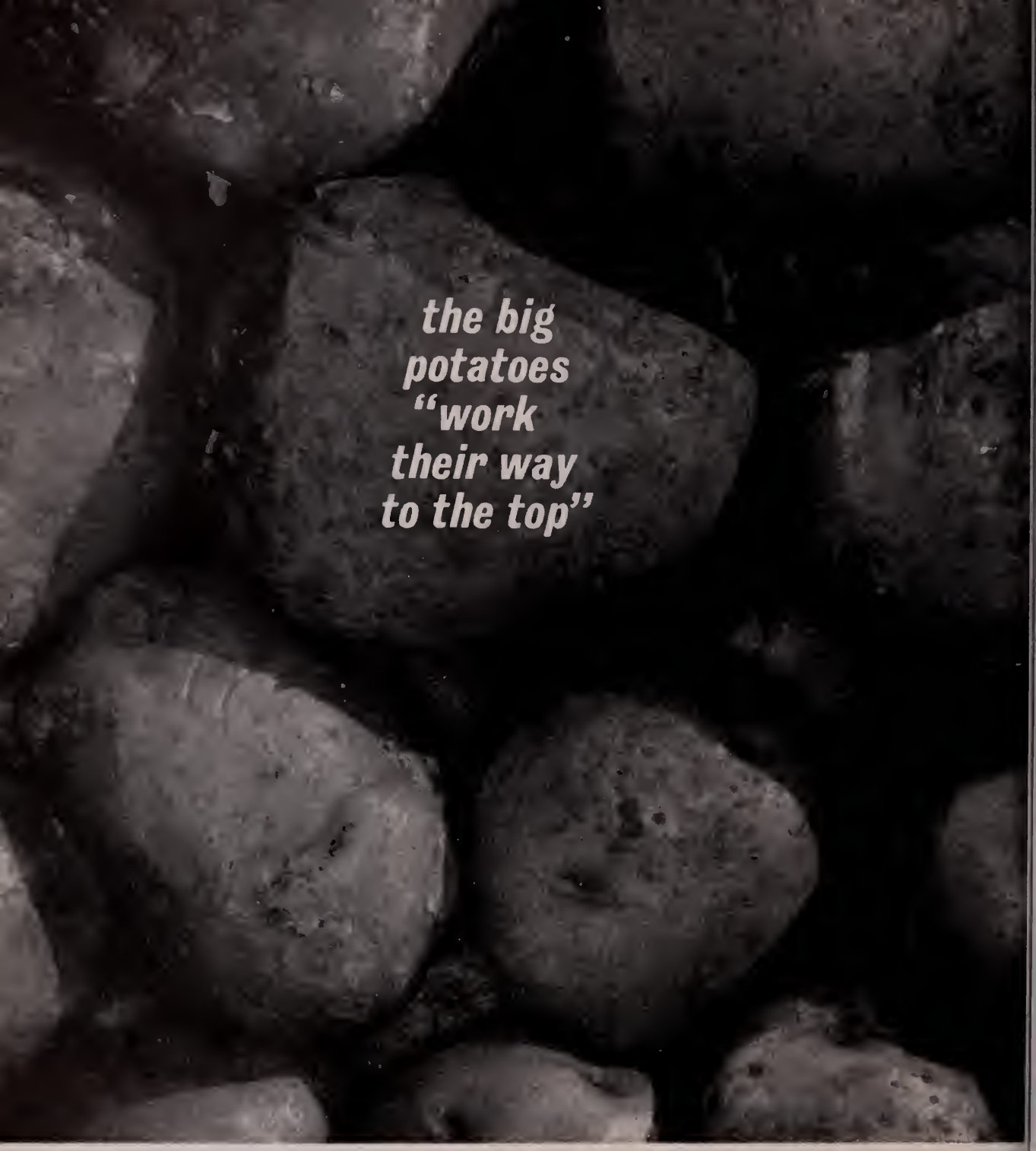
brand of trichlormethiazide

Reduces elevated blood pressure while providing symptomatic relief...permits more normal activities...liberalizes salt intake...in severe hypertension, potentiates other antihypertensives...as a diuretic, controls edema with minimal, once-daily dosage.

Supplied: NAQUA Tablets, 2 and 4 mg., scored, bottles of 100 and 1000.

For complete details concerning NAQUIVAL and NAQUA, consult Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Bloomfield, N. J.

S-160



Jostle a peck of potatoes long enough and the little ones will fall to the bottom; the big ones work their way to the top. So do the larger particles of an admixture of powdered chemicals. Unless steps are taken to keep particle sizes uniform, the active ingredients will not be evenly dispersed throughout an excipient. That is why Lilly pharmaceutical chemists establish precise specifications; maintain rigid controls. A few more steps are added and the cost is slightly increased, but priceless uniformity is assured in the finished product.

Eli Lilly and Company · *Indianapolis 6, Indiana, U.S.A.* Lilly

390024

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Medicine's Investment in Blue Shield

In the first six months of 1962, Blue Shield Plans paid for nearly a half billion dollars worth of professional services in the U.S.A. By any yardstick, Blue Shield is a major factor in the medical economy today. And it is *the one operative factor controlled by the profession.* Blue Shield is the only program that reflects medicine's ideas as how a prepayment plan should be operated, what services it should cover, on what terms, and with what reimbursement.

Several hundred commercial accident and health insurance companies, in aggregate, cover more people and pay out more money in the course of a year than do the 75 Blue Shield Plans. But we think that it is Blue Shield that has set the pace and established benefit patterns and fee schedules at levels that will substantially protect the patient and reasonably compensate his doctor.

What has medicine invested in Blue Shield? Thousands of dedicated doctors have given lavishly of their time and energy as trustees, directors and committee members in their local Plans. Thousands more supported their efforts by providing services under arrangements which, in early days, represented a substantial contribution to the Blue Shield program as well as to the welfare of their patients and the freedom of our medical care system.

But this investment has led to benefits vastly more important than even the billion dollars worth of medical services it is underwriting this year. Our investment in Blue Shield symbolizes a solid demonstration of the ability of physicians—working together with labor, industry and community leaders—to solve the economic problems of modern medicine without recourse to government. Blue Shield is a strong and versatile instrument by which medicine can continue to guide the economy of medicine in the days ahead.

Published Monthly Since 1904

Henry A. Davidson, M.D., *Editor*

Under the Direction of the Committee on Publication
Frank L. Rosen, M.D., *Chairman*

Theresa E. Goeke, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the Society is entitled to receive a copy of The Journal every month

Whole Number of Issues 703

Vol. 60, No. 3 March, 1963

Single Copies, 30 Cents
Subscriptions, $3.00 per year

The Activist Philosophy in Medicine

We pride ourselves on our American activist culture—on the drive towards *doing* something. Idleness seems like a sin, and every crisis calls for action. Passivity is almost a term of contempt. In industry this has led to our prosperous, booming dynamic economy. Our astronauts have converted "go" from a verb into an adjective, as if, by that mobile word, to characterize all of us.

In medical practice, there is a similar drive towards action. A consultant would feel that he wasn't earning his fee if he told the patient to do nothing. Self-limited mild illnesses like the common cold can be adequately treated by keeping our hands off the patient and our prescription pads untouched. We know it, but we can't stand the passivity of such an approach—and our patients demand action anyway. We have an itch towards instrumentation and by now have developed scopes for peering into every opening in the human body and even probing into some we have to make for the purpose. In the hierarchy of American medicine, the surgeon or surgical specialist gets the limelight—as any TV watcher can tell you. An Osler might look at a patient quietly and notice the dusky fingernails or the odd gait or the peculiar stance and thus draw an ingenious diagnostic conclusion—which leads (in Osler's own term) to "masterly inactivity." But today, that won't get much of a TV rating compared to the dramatic activity of the surgeon. Patients expect to pay surgeons well. They feel that something spectacular has been done—and they can *see* (or feel) the results. Even insurance companies (not excluding Blue Shield plans) seem to see it that way—as reflected in fee schedules, at least.

Perhaps it is impossible to stem the tide towards more instrumentation, more activity, and more medication. But this may eventually mean that, in medicine, knowledge and wisdom will be replaced by dexterity and technic. If so, this will be a pity, for it suggests that the doctor will forfeit his title as an intellectual and acquire instead the status of the skilled craftsman. It would be too bad if contemplation is squeezed out by the passion for action.

Family Doctor and Mental Health

We open this issue of The Journal with an article on the general practitioner's responsibility in the care of the emotionally ill child. As a matter of fact, the family doctor's responsibility covers the entire range of emotional illness. In simpler times, the family physician was consulted when any member of the family showed mental or emotional symptoms, took to alcoholism or drug addiction, or became involved in delinquency. With the development of a network of agencies, psychologists, probation offices, and diverse social service resources, the family doctor's role tended to recede. This was not due to undue aggressiveness on the part of these other facilities, but rather to the reluctance of the physician to involve himself in these social problems.

A half century of this has almost put the doctor out of consideration when a family is in trouble because one of its members is exhibiting evidences of social pathology. Some physicians feel that they are too busy to become involved in this. Some feel unequipped to handle these problems which, after all, do require something more than good intentions and common sense. And, let's confess, some doctors find it unpleasant to work at all in this area; and as rapidly as possible unload these responsibilities on a non-medical agency.

Yet we cry constantly for the rehabilitation of the family doctor. As a first step in this rehabilitation, the general practitioner should welcome the opportunity to serve as a consultant to the family on its emotional as well as its physical problems. A progressive state like ours has many psychiatrists and specialized agencies available to backstop the doctor in his efforts. But he should still be the first line of defense in the battle against emotional illness.

Edward P. Duffy, Jr., M.D.

Belleville

Family Doctor's Responsibility in the Care of the Emotionally Ill Child*

Although the care of the emotionally ill child requires highly specialized handling, the family physician has an indispensable pilot role as Dr. Duffy here shows.

New Jersey has a proposed master plan for the care of the mentally ill in our state. The proposals include several basic concepts and also long range aims which should have a place in such a plan, especially related to children.

The family doctor is often the first professional person to recognize emotional disturbance in young patients. He is the one primarily concerned with organizing the planning for treatment whether long-range or short-range. The family doctor working with children is in an ideal position to plan the transition from the doctor's office to a special treatment facility, if that is needed; and to continue with the rehabilitation after discharge from the referral center.

This trend toward coordinated treatment has been developing slowly but is now emerging under the proposed master plan for mental health services for children in New Jersey.

SPECIAL HOSPITALS

The public mental hospital is not always the answer to a child's or youth's needs. Some other facility might better serve the child; but what is it? And does it exist? Is there some treatment resource available between the out-patient psychiatric (Child Guidance) clinic and the State Hospital? Too frequently, in many areas of New Jersey the answer is "no." The doctor is faced with prescribing a course of treatment; but the needed facility is nonexistent. The problem is becoming even greater because of the increasing number of children suffering from disorders which range from a relatively mild behavior problem to a more severe emotional disturbance. (I omit reference to severely psychotic children who must be institutionalized.)

It is not possible at this time to determine whether the greater incidence of emotional illness in children is due to expanded and improved laboratory methods of diagnosis or whether, in fact, there are larger numbers of emotionally disturbed children (regardless of the etiology) in our general population.

EDUCATIONAL FACILITIES

The important point is that we need a dynamic approach to the provision of facilities for the diagnosis and treatment of the emotionally

*Read by invitation, April 1, 1962 before the Miami (Florida) Assembly of the National Association for Mental Health.

disturbed child. Such new facilities should also aid parents in coping with "problem children" if the parents need counselling or treatment. These programs might include education of the emotionally disturbed child. The new statute providing for the education of the emotionally disturbed and socially maladjusted child has brought into sharp focus the dearth of facilities for these children. The new Beadleston law (passed in 1959) provides for many types of services, depending on the specific needs of each child. But many of the recommended facilities do not now exist in New Jersey. A splendid blueprint has been proposed but its full implementation is yet to take place, even though great strides are being made every year. Under this new law, a child study team has been established under the State Commissioner of Education. In three counties, comparable teams have been appointed, consisting of a psychologist, social worker, remedial instructors, and, in two instances, a psychiatrist. It then becomes permissive for local Boards of Education to avail themselves of State financial aid by appointing similar local teams. Very few local boards have taken advantage of the new law. If they are encouraged to do so by interested citizens, a large step forward will have been taken in aiding children with emotional problems because, with appropriate professional help, many such children can stay in school, and at home. This is especially true if short term intensive diagnostic treatment facilities are available at a local or regional hospital. If this is then combined with "open door" or day and night residential centers for children and adolescents, a reasonable spectrum of services would be available in a community.

OUT-PATIENT FACILITIES

AMONG the needed resources are psychiatric services at a low cost such as the one which has been organized in Essex County for adults.†

If such a service were available for adolescents, school referrals would be eased. Part-time professional personnel could render services as needed. These would include a psychologist, psychiatric social worker, and a psychiatrist who would see patients referred to them in their private office or elsewhere, but at reduced fees, mutually agreed upon.

NURSERY SCHOOLS

ANOTHER important service is the nursery school for emotionally disturbed children or families in conflict where children would benefit by a neutral environment both public and private. These should be established under the direction of physicians. They would aid in the development of responsibility to supplement the home training. Many nursery schools and day nurseries will not accept children with serious behavior problems; consequently, preschool children who need a different environment for a part of the day have no resource to which they can turn. Fewer behavior problems might be admitted to the grade schools if there were such facilities available to deal with them at an early age.

RESIDENTIAL CENTERS

RESIDENTIAL treatment centers are desperately needed for certain children. These are particularly beneficial for children who require manipulation of their environment for a period of time. Such centers exist at the present time, but they are able to care for only a limited number of children; and only the more severely disturbed are admitted. The public facilities now in existence (Highfields, Arthur Brisbane, and Neuropsychiatric Institute) can care for only small selective groups. Admission is limited to referrals from the courts, and public and private agencies. Private physicians are generally unable to have their patients admitted to these facilities; thus, only a trifling ratio of the total child population suffering from disorders may be accepted. While

†The Low Cost Psychotherapy Plan, East Orange, N. J.

they serve a definite community need, it is clear that additional facilities are needed to serve the rest of the population.

GENERAL HOSPITALS

IN THE enfolding pattern of services which need to be developed, which is under discussion, one vital facility is the psychiatric unit in the general or pediatric hospital. These units could be established in every general or pediatric hospital of 100 or more beds. They would provide complete diagnosis for children exhibiting some mental dysfunction, followed by short-term intensive therapy; perhaps limited to a 90-day stay. Among the many advantages of such a facility in a general hospital is the proximity to the home, the absence of stigma (which, unfortunately, is still connected with public mental hospitals) and the continuity of care possible because the family physician is available for treatment planning and consultation follow-up and rehabilitation at all times. He also has at hand the medical specialists needed to help his consulting psychiatrist consider the total child in the total environmental setting.

Hospital care both for the newborn and the older child and /or adolescent in the pediatric department of the hospital might well be modified to incorporate hospital care as we know it today with the best aspects of home care. It is psychologically important not to disrupt the family during hospitalization of one of its members. If hospitals could be sufficiently flexible in their programs so that (unless contra-indicated in specific cases) families could visit at will in the hospital, there would be an easier transition into and out of the institution. In the past, when babies were delivered at home, there were many advantages derived because family unity remained intact. Scientific advances have made home delivery impracticable and often dangerous; but a combination of the best features of each has real merit. Hospitalization is often a traumatic experience for a child. This could be alleviated in large measure by technics whereby the child and mother do not feel isolated from the family. In the obstetrical department, too, this approach has psychologic value because both parents and siblings now excluded from visitation, would, from the beginning, share in the care of a new member of the family.

STAFFING

IN PLANNING for all these facilities, the question of staffing immediately arises because of the dearth of professional personnel. One source of personnel is women who have worked before marriage and who might, after retraining, be reclaimed for employment. Others might also be encouraged to take the necessary professional training to work in this field, if professional opportunities were close enough so that the home would not suffer by the mother's absence.

A NEW APPROACH

FROM the foregoing, it is evident that a whole new approach is developing in planning for the care of the mentally ill child. A total realignment of all professional resources in the community to achieve the most efficient use of all is indicated. The "open door" policy of many mental hospitals might be extended to doctors both in the community and in the mental hospitals. This would permit a doctor in private practice to continue to see (treat) his patient in the mental hospital if he desired and was qualified. Conversely, doctors in public agencies could help train all students in mental health careers and also care for State or "medically indigent" patients in private hospitals and clinics. This plan might well be extended to all ancillary personnel who treat mental illnesses in children. This could provide an integrated approach, with teamwork of the whole professional community.

The report of the Joint Commission on Mental Illness and Health has focused on the

need for improved attitudes and methods in treating the mentally ill. Even though the report did not specifically refer to problems of children, many of us concerned with this age group have accelerated the search for new technics of diagnosis and treatment.

We hope that the doctors of this state will cooperate in the establishment of these facilities; and that they will participate in care or referral of the emotionally ill child whether or not drug therapy is indicated.

Since this article was submitted, the AMA-sponsored Congress on Mental Illness (Chicago, October 1962) has stressed the importance of the nonpsychiatric physician in the care of the mentally ill and emotionally ill.

379 Washington Avenue

Merger of CARE and Medico

Announcement has been made of the merger of two of the country's most respected voluntary agencies concerned with international assistance: CARE and MEDICO.

CARE was founded in 1945, as the Cooperative for American Remittances to Europe to meet the needs of European nations shattered by war.

The current name, Cooperative for American Relief *Everywhere,* signifies changes in emphasis over the last sixteen years. The volume of aid given during this period has been around a half-billion dollars. CARE is a cooperative of 25 member agencies.

As conditions improved in Europe, CARE terminated its services in many European nations and started programs in the developing nations of Asia, the Middle East, Latin America and Africa. Services are now given in 32 nations.

Newest members of the CARE "family of nations" are Liberia, Cyprus and Sierra Leone and negotiations are being conducted on the possibilities of establishing CARE missions in Nigeria, Cameroon, Tanganyika, the Dominican Republic and British Honduras.

CARE is best known for its program under which thousands of tons of food and other essentials have been sent to more than 50 countries. Last year these shipments included surplus agricultural commodities, valued at $33,700,000, contributed by the United States Government.

Such supplies are usually used for school lunch and institutional feeding programs conducted in cooperation with the host government and for family-welfare and disaster-relief feeding.

Of equal importance, however, is the second aspect of the CARE program under which the tools of education, health and self-support are provided the needy to aid them in helping themselves.

MEDICO, founded in 1958 by the late Dr. Tom Dooley and Dr. Peter Comanduras, was organized to establish hospitals and provide American physicians and personnel to staff them in newly developing areas. It follows the same "people to people" concept of CARE, except MEDICO is "physicians to people."

In the last two years these programs have treated 250,000 persons. MEDICO has shipped abroad gifts of drugs and other medical supplies valued at more than $3,000,000.

One of MEDICO'S special projects is an International Eye Bank. Under this program, American ophthalmologists travel to remote places taking with them a supply of preserved human corneas contributed by American eye banks from surplus stock.

Another special project, Orthopedics Overseas, consists of leading American orthopedic surgeons' going to a country on a rotating basis to provide surgery and teach.

This program, which started in Jordan, has been expanded to Saigon and Vietnam, and will include countries in South America and Africa.

MEDICO is affiliated with the American College of Surgeons and the American College of Physicians.

That the American people believe in CARE and MEDICO is shown by their consistent increased support of these organizations. Contributions to CARE doubled since 1956.

Under the new merger, MEDICO will continue and expand its current program; CARE will gain a professional arm for the medical supplies and equipment that form part of its self-help assistance.

Food, tools and professional skills will be combined in a joint assault on mankind's greatest enemies—hunger, poverty and disease.

Eugene P. Salvati, M.D.

Plainfield

The Treatment of Ulcerative Colitis

Analysis of 82 Cases

Modern treatment methods, judiciously used, led to a high salvage rate in ulcerative colitis: only one patient in seven required surgery.

Of 82 cases of ulcertive colitis seen by the author over a five-year period, 57 were followed long enough to provide some insight into the management of the disease as it is seen in the typical medium-size community. The cases seen represent two per cent of the total number of new patients examined (3,775).

Average age of onset was 36—considerably higher than that reported by most authors. Nine were under the age of 20, and ten were over the age of 50. Ages ranged from 13 to 85. Fifty-eight per cent (47) of the patients were female. This sex differential is similar to the findings of others. Sixty-three patients were married, fourteen single, four widowed and one divorced. Only one of the 82 cases was a Negro. This is in a community in which 15 per cent of the population is Negro.

Most of the patients presented themselves with bleeding, diarrhea and cramps in that order. Seven complained of constipation. Average duration of symptoms was 6½ months. Thirty-four per cent (28 patients) had had previous attacks.

Sigmoidoscopy revealed the disease to involve the full 25 centimeters of the lower bowel in 62 per cent (51 cases); from the dentate line to the five-inch level in 26 per cent (27 cases); confined to the rectosigmoid in six per cent (5 cases); and from the five to the ten-inch level in three per cent (3 cases). One patient with a segmental colitis involving the transverse colon had a negative sigmoidoscopy. The mucosal changes were typical of ulcerative colitis: edema, injection, ulceration, bleeding and granularity. Pseudopolyposis was noted in four cases.

Thirty-nine barium enemas were obtained in the 82 patients. Thirty per cent (12 cases) were reported as negative. Analysis of the negative reports showed that six had sigmoidoscopic changes confined to the terminal five inches of the bowel; five had mucosal changes involving the terminal ten inches, and one had a segmental colitis.

Thirty (27 per cent) had anorectal complications. This is similar to that reported in the literature. Fifteen per cent (13 cases) had severe pruritus ani; 7 per cent (6 cases) had anal fissures; 7 per cent (6 cases) showed rectal strictures. There were two cases of anal stricture, two of severe hemorrhoidal bleeding and one rectovaginal fistula. Pyoderma was present in one case and arthritis in one other. Sixty-nine per cent (57 cases) were seen on an average of ten office visits, varying from three to 37. The remaining 25 patients were examined only once or twice. Treatment was either continued by the referring physician or the patient did not return for further care.

Treatment included the non-absorbable sulfa drugs orally; hydrocortisone suppositories locally; the corticosteroids; and, lastly, surgery.

Phthalylsulfathiazole (Sulfathalidine®) 1.5 Grams four times a day, was used in 27 cases with 63 per cent (17 cases) responding adequately. The drug was given for at least a month initially and continued for one to two weeks out of every month thereafter, for varying periods of time. Side effects with this drug were infrequent.

Salicylazosulfapyridine (Azulfidine®) was used in 49 cases with a 63 per cent response (32 cases). The usual dose was one Gram four times a day in a manner similar to phthalylsulfathiazole. The recommended dosage is six to eight Grams a day. Bothersome side effects were present in eight cases (16 per cent). These included headache, nausea and rash, which necessitated discontinuing the drug, although in several cases it was used again in smaller doses.

Thirty-six per cent (21 cases) of 57 patients received corticosteroids in one form or another. Fifteen patients were given a 15-day course of ACTH followed by methylprednisolone four milligrams four times a day for one to four months. In three there was a good response and in two a fair response. Ten showed no clinical improvement. Two patients received prednisolone 10 milligrams four times a day. In one there was an excellent response. The other did not respond. Recently, a new drug (not yet released for general use) has been tried in four patients with a good response in all. This is Dichlorisone® and is used in a dose of 40 to 50 milligrams per day. Thus far, of the 21 cases treated with corticosteroids, 47 per cent (10 cases) responded favorably. Corticosteroids were used only after all other therapeutic measures had failed to elicit a clinical response.

In 46 of the 57 treated, a suppository containing 10 milligrams of hydrocortisone (Wyanoids®) was used twice daily. Seventy-six per cent (34 cases) of the patients responded favorably. The course of treatment varied from one to three months with the suppositories being reduced to once daily after one month.

Forty-five patients received Diodoquin® empirically. Other drugs used were Cantil®, Lomotil® and tincture of opium to control the diarrhea and cramps. Diet was not stressed except for a restriction on high residue foods when diarrhea was a problem.

Thirty-five per cent (29 cases) of the 82 patients required hospitalization for their disease. Average time of treatment before the sigmoidoscopic findings were essentially normal was 3.7 months. In other words, in patients who did respond to medical treatment, it took three to four months before the mucosa reverted back to a more normal appearance. This, however, varied from one to 28 months. Clinical improvement always preceded sigmoidoscopic improvement.

In 22 per cent (13 cases) of the patients treated the colitis never improved and surgery was necessary in nine (15 per cent). The remaining patients were able to carry on despite their disease. Twenty-four patients averaged one attack per year, and 13 averaged two attacks per year. In one, three attacks occurred in one year and in another four attacks. In five patients the interval between attacks varied from two to seven years.

SURGERY

In the 15 per cent (9 cases) who required surgery, six were operated upon by the author and three elsewhere. There was one case of an acute fulminating colitis for which an immediate subtotal colectomy and ileostomy was carried out. Active disease is still present in the rectal stump, but it is kept under control with local corticoids. In two cases, a one-stage coloprotectomy and ileostomy were done and both patients are doing well. A subtotal colectomy and ileostomy followed by a proctectomy were done in one patient and he is doing well. One patient had a subtotal colectomy and anastomosis of the cecum to the rectum. Later, an anastomotic leak necessitated a proctectomy and ileostomy. This patient is now well. In one patient with an ileitis and

segmental colitis, resection and colostomy were done. This patient still has active rectal disease but is doing well. Two deaths occurred in the nine cases. A colostomy was performed on one patient for a perforated carcinoma with generalized peritonitis and abdominal metastases. The patient expired hours later. One moribund patient had a subtotal colectomy and ileostomy but died of peritonitis eight days later. One patient had an exploratory laporatomy which revealed an extensive granulomatous transverse colitis. This patient was closed without any surgery and has done well since.

All patients who survived surgery are completely rehabilitated. There was one medical death, a patient who contracted homologous serum hepatitis after being transfused 2½ months before.

EMOTIONAL FACTORS

AN ATTEMPT was made to evaluate the emotional factor in the 57 patients that were followed. It was felt that there was a large psychosomatic component in 64 per cent of these patients (37 patients). Thirty-two per cent of this group received tranquilizers and one was under voluntary psychiatric care.

COMMENT

THE large proportion (30 per cent) of negative barium enemas in the presence of active disease points out the importance of a sigmoidoscopic examination. This is no reflection on the radiologist but is inherent in the disease. Another appropriate comment here, is that a physician who is not familar with the endoscopic changes and is not prepared to carry out frequent sigmoidoscopy should not undertake to treat this disease. I personally feel that every internist and general practitioner should be thoroughly versed in sigmoidoscopy.

In intractable pruritus ani with negative sigmoidoscopic findings, one should occasionally suspect a subclinical case of ulcerative colitis. Two patients with severe pruritus were treated for one year before they developed mucosal changes indicative of colitis.

Hydrocortisone suppositories appeared to be especially valuable in patients whose disease was confined to the rectum and rectosigmoid. Suppository therapy has several distinct advantages. One advantage is its poor rate of absorption with subsequent lack of side effects. Another is patient cooperation in using the medication in contradistinction to enemas containing corticosteroids. The author feels that suppositories have an important place in the management of ulcerative colitis though little mention of this is made in the literature.

The dosage level of Azulfidine® as recommended by some would certainly result in a high incidence of intolerance, as 16 per cent of the patients treated with a total daily dosage of four Grams developed adverse reactions necessitating discontinuance of the drug or lowering the dosage. The author still feels, however, that it is a good drug and superior to sulfathalidine.

Empirical treatment of all ulcerative colitis patients for amebiasis by the use of Diodoquin® is debatable but not objectionable. However, one must not be fooled into thinking that he is dealing with amebiasis if the sigmoidoscopic findings revert to normal as ulcerative colitis will also respond to this drug.

Sixty-five per cent of all ulcerative colitis cases treated in this series did not require hospitalization. This is an important point as it shows that the majority of these patients can be managed with office treatment.

All patients who required and survived surgery were completely rehabilitated.

SUMMARY

1. A series of 82 cases of ulcerative colitis is presented. Of these, 57 were followed from one to 60 months.

2. Sigmoidoscopy proved to be an essential part of the diagnosis and treatment of the disease.

3. Treatment consisted of the nonabsorb-

able sulfa drugs, hydrocortisone suppositories, corticosteroids and surgery.

4. Three-fourths of the patients treated responded to hydrocortisone suppositories; 63 per cent responded to nonabsorbable sulfa drugs; 47 per cent responded to the corticosteroids and 15 per cent required surgery.

5. Two-thirds of the patients were adequately controlled with office treatment and 35 per cent required hospitalization.

1009 Park Avenue

BIBLIOGRAPHY

1. Bacon, H. E.: *Ulcerative Colitis.* Philadelphia, 1958. Lippincott. Page 340.

2. Bargen, J. A.: *Chronic Ulcerative Colitis.* Springfield, 1962. Thomas. Page 17.

3. Jackman, R. J. and Mayo, C. W.: *Chronic Ulcerative Colitis—Anorectal Complications.* Surgery, Gynecology and Obstetrics, 98:478 (1954).

4. Kirsner, J. B.: World Wide Abstracts of General Medicine, 2:9 (August 1959).

5. Korebitz, B. and Janowitz, H. D.: *Diseases of the Colon and Anorectum.* Philadelphia, 1961. Saunders. Pages 659 through 701.

The Twist and Ovarian Torsion

Another medical complication of the current dance craze, 'the Twist," has been reported from Montreal. Dr. Howard S. Root describes an ovarian cyst which underwent torsion "during the gyrations of a lady engaged in this dance routine." The offending lesion was promptly removed and submitted to the Department of Pathology for examination. —*Canadian Medical Association Journal,* Feb. 24, 1962.

Placebos Help Mental Patients

Two placebos were given to a group of patients in the study conducted at the New York Hospital, Westchester Division, White Plains, N. Y. This is reported in the June 17, 1961, Journal of The American Medical Association.

The patients, their psychiatrists and their nurses were told that one placebo was a new tranquilizer and the other a new psychic energizer. All three groups filled out questionnaires on the effect of the pills each week of the six-week study. It was found that 70 per cent of the patients were helped by the placebos.

The study involved 70 women and 50 men ranging in age from 13 to 77. More than half had been educated beyond high school. Neither severely disturbed nor nearly recovered patients were included.

The researchers also made a comparative study between patients who received the placebos and a control group who did not receive any pills. The patients were rated every week by a head nurse on a behavioral scale.

In the tranquilizer study, those who received the placebo "improved significantly more than the control group on over-all behavior," the researchers reported. In the energizer experiment there was no significant difference between the two groups. This might reflect the fact that tranquilizers have been much more readily accepted.

The study illustrates the tendency to ascribe improvement to what is believed to be an active drug and the discrepancy in results obtained with subjective and objective methods. Studies which do not employ double-blind and controlled procedures are of dubious value. This project was conducted by Armand W. Loranger, Ph.D., Curtis T. Prout, M.D., and Mary Alice White, Ph.D.

Alvin A. Florin, M.D.
South Orange

Aaron M. Rosenthal, M.D.
Trenton

The Camden County Demonstration Stroke Project*

A Preliminary Report

The usually hopeless attitude towards "stroke" is not always justified. With intensive management and good team work, a commendable salvage ratio may be reached.

In July, 1961, a demonstration "stroke" program was instituted at two general hospitals in Camden County, New Jersey. This project has been functioning for eight months and this communication is a preliminary report covering that period.

Several factors were instrumental in the initiation of this project. Deaths from vascular lesions affecting the central nervous system are the third leading cause of death in New Jersey. They total about 5000 a year: a figure which has remained fairly constant for the past 10 years.

The State Department of Health has encouraged and supported rehabilitation of stroke patients in chronic disease hospitals, nursing homes, and rehabilitation centers. This project attempts to demonstrate the importance of the *treatment* of the stroke patient early in the disease before contraction and deformities have occurred.

While a facility for the rehabilitative treatment of chronically disabled patients exists in this county, the waiting period for admission from general hospitals or directly from homes was sometimes lengthy. Patients frequently were admitted who had extensive flexion deformities and contractures. As a consequence, these patients were either non-rehabilitable or required a lengthier treatment time. After the program was instituted (through cooperative efforts of the medical staff and admitting office) patients with acute strokes were given priority for admission whenever feasible.

There exists a real need to develop programs for the treatment of cerebrovascular accidents with resultant hemiplegia. According to U.S.P.H.S. figures [2] there are at least two million hemiplegics in this country. This makes it, by far, the most important single, disabling condition affecting our adult population.

Finally, it was believed that a direct attack upon the hemiplegic problem would serve two

*This work is from the Camden County Stroke Project of which Dr. Rosenthal is Medical Director, Dr. Florin is Program Coordinator of the Heart and Circulatory Disease Program of our State Health Department.

ends. *First*, it might succeed in physically restoring a large number of disabled victims; *second*, it might allow vocational salvage for some of them. These goals could best be achieved by an enlightened approach using trained medical and paramedical personnel as part of a team.

The project was never intended to be experimental. Lowenthal [1] and others have shown that there is a great advantage to the rehabilitation approach to the hemiplegic patient. Our hope was to demonstrate to both the medical and lay community the feasibility and the advisability of such a project using the team approach.

PERSONNEL

SINCE no rehabilitation facility for acute stroke cases was available, the chronic disease section of the New Jersey State Department of Health provided funds to underwrite part of the costs of the project. Contracts were written with West Jersey Hospital, Cooper Hospital, and the Camden County (New Jersey) Visiting Nurse Association, for professional and secretarial services. These funds made it possible to insure that all of the participating agencies would be reimbursed for their services.

A physiatrist was appointed to organize and direct the team at both hospitals. Team members included the paramedical personnel already employed at each of the hospitals. We were convinced that an effective program could be developed utilizing the skills and experience of the people who were already working in the community. Physical therapy departments were already functioning at both institutions. We decided to utilize these in the treatment of hemiplegic patients.

The physical therapists at each hospital served as foundations for our team. In addition, nurses were included at each institution, and a program for educating them in rehabilitative nursing was begun by the medical director. Weekly orientation lectures were given to the nurses.

From the social service department at each hospital, one social worker was assigned to be a part of our team. Each dietary department added a dietician to our group. There were no occupational therapists available at either hospital, but we did recruit one from the Camden office of the Society for Crippled Children and Adults. This participating voluntary organization also supplied a speech therapist. Both the occupational therapist and the speech therapist were available to us at both hospitals on a part-time basis.

At Cooper Hospital an associate physician from the medical service was assigned as liaison between the medical staff and our team. This was beneficial in resolving administrative problems as they arose. Thus, we had as team members the essential people for rehabilitation. We patterned our team and its function after that of a rehabilitation center. The significant difference was that, as part of a general hospital, we were not equipped to treat our patients quite so intensely. The physiatrist did not assume responsibility for the general medical care of the patient nor did the Program assume any obligation for the financial care of hospitalization.

To provide for the needs of our patients after their discharge from the hospital, arrangements were made to assign a visiting nurse to each hospital team to carry out such orders as were indicated and to keep the team appraised of the patient's post-discharge course. Fortuitously, we also were able to supply a part-time homemaker, when indicated, to help in the home when we believed that such help might be of benefit.

PROGRAM

THE project evolved as a consulting service to the medical staff. Each hospital committed their ward cases to us; but we wanted to treat private patients as well. The medical director of the project spoke before both medical staffs, and explained our program. Staff physicians were urged to refer private cases to us for evaluation so that we could initiate

a rehabilitation program. We asked only that the patient be encouraged to be followed by us for six months properly to evaluate his progress and disposition. The response from the staff physicians was most gratifying.

Once under way, we met for a combined team conference once each week at each of the hospitals. The physiatrist made rounds at both hospitals twice weekly, and wrote all orders for physical therapy, occupational therapy, speech therapy, and special nursing orders regarding rehabilitation. Each patient was discussed at a conference shortly after his acceptance to the program. He was the subject of at least one more conference prior to his discharge from the hospital, and again, at the end of the six months' follow-up period. More conferences were held for problem cases. At these conferences, each team member discussed the patient from his own point of view.

The physical therapist might talk about range of motion, muscular weakness, spasticity, gait training, or the need for bracing. The occupational therapist discussed self-care activities, including dressing, feeding, washing, shaving, and grooming. The nurse talked about transfer activities, bowel and bladder training, positioning to prevent contractures, and feeding activities. The social worker told us about the family constellation, the economic picture, and plans for post-hospital discharge. The speech therapist evaluated the aphasics and the diarthrics and provided therapy when indicated. The dietitian told us about the nutritional problems and how they were being met. The visiting nurse kept us appraised of the patient's progress, problems, and activities following his discharge from the hospital.

Each patient was treated daily by the physical therapist, and twice weekly by the occupational and speech therapist. Our program was individualized for each patient depending upon the severity of the disability and upon any other complicating conditions. Each patient referred for evaluation was seen by the physiatrist to determine feasibility for rehabilitation. Only two basic criteria were necessary for acceptance to the program. First, the patient must have had a hemiplegia, and second, the patient must have been a resident of Camden County. If accepted, the program began immediately. This included bedside physical therapy if the patient was too ill to go to the physical-therapy department. Proper positioning, foot board, and cock-up splints were ordered as indicated. Bowel and bladder retraining were initiated, and self-care activities training was begun. As the patient progressed, the program was intensified. As soon as sitting balance was adequate, the patient was taken to the physical therapy department for muscle strengthening exercises, balancing exercises, and gait retraining. Goals were to achieve as much independence in self-care activities as possible, including independence in ambulation. In addition, vocational goals were set for the younger patients with sufficient neurologic return.

RESULTS

TABLE 1 summarizes some facts about patients treated in the first six months at Cooper Hospital. Thirty-four patients were ac-

TABLE 1.

COOPER HOSPITAL

	Number	Per Cent
Total patients accepted	34	100
Patients expired	12	35
Patients withdrawn	3	9
Patients survived and followed	19	56
Ward patients survived	4	21
Private patients survived	15	79
Males	8	42
Females	11	58
Age range	40 to 78	
Average age	67	
Thrombosis	16	84
Hemorrhage	1	5
Embolus	2	11
Right peripheral involvement	9	47
Left peripheral involvement	10	53
Aphasia†	7	37
Days of hospitalization (Range)	10 to 54	
Days of hospitalization (Average)	29	

†All aphasic patients had involvement of left brain (right extremities).

cepted by us for our project. Of these, 12 expired, ten in the hospital, and two shortly after discharge. This is a mortality of 35 per cent. Three patients were withdrawn from the project for other reasons, and 19 survived and are being followed. Of these 19, four were ward patients and fifteen were private cases. The 19 included 11 females (58 per cent). The group ranged in age from 40 to 78, with an average age of 67; an elderly distribution as one might expect in this disease complex. In regard to etiology, cerebral thrombosis was most common, accounting for 16 cases (84 per cent); cerebral embolus was responsible in two (11 per cent); and cerebral hemorrhage in only one (five per cent). The side of involvement was evenly divided between right and left. Seven of the right hemiplegics had an associated aphasia. The length of hospitalization varied from ten to 54 days with an average stay of 29 days.

TABLE 2

COOPER HOSPITAL

	Number	Per Cent
Discharged to home	11	73
Discharged to nursing home	4	27
Still hospitalized	4	
Activities of daily living		
Independent	7	47
Partly Independent	7	47
Dependent	1	6
Returned to work		
or household duties	6	40
Did not so return	9	60

Table 2 contains further data. Of the 15 discharged from the hospital (at the time of this report) 11 returned to their homes. Only four required transfer to nursing homes. This demonstrates the degree of improvement, since patients who remain a nursing burden are not often accepted by their families back into their homes. In regard to daily activities, three classes are noted. Those who were able to care for themselves completely without any assistance were called "independent." There were 7 in this group (47 per cent). Those who needed some assistance in these activities (dressing, feeding, grooming, transfer, walking, and so on) were called "partly dependent." There were 7 (47 per cent) of these. Patients who needed assistance in all of these activities were put in the "dependent" class; and there was only one (six per cent) in this group.

The final evaluating factor was the determination of the number of patients who were able to return to work or were able to return to the full-time care of their household responsibilities. Six patients of the 15 were able to do so (40 per cent); and nine patients (60 per cent) were not. Although our group total is a small sample, we are gratified by the number of patients who achieved both physical and vocational rehabilitation. Our figures are comparable with those published from rehabilitation centers.[3] It should be noted that we never tried to select our patients in terms of involvement. All cases were accepted regardless of the severity of neurologic deficits.

Table 3 summarizes similar data from West Jersey Hospital. Twenty-seven patients were

TABLE 3

WEST JERSEY HOSPITAL

	Number	Per Cent
Total patients accepted	27	100
Patients expired	13	48
Patients withdrawn	1	4
Patients survived and followed	13	48
Ward patients survived	5	38
Private patients survived	8	62
Males	5	38
Females	8	62
Age range	51 to 79	
Average age	68	
Thrombosis	11	86
Hemorrhage	1	7
Embolus	1	7
Right peripheral involvement	6	46
left peripheral involvement	7	54
Aphasia†	2	15
Days of hospitalization (Range)	12 to 58	
Days of Hospitalization (Average)	25	

accepted, of whom 13 (48 per cent) expired in the hospital. One patient was withdrawn, and 13 (48 per cent) survived and are being followed. Of these 13, eight were private cases. Only five of the 13 were males (38 per cent). Their ages ranged from 51 to 79 with an average of 68 years.

Eleven (86 per cent) of the 13 disabilities were due to cerebral thrombosis, and one each due to cerebral hemorrhage and cerebral embolus. All of these diagnoses were made on clinical grounds. We were dependent upon the diagnostic acumen of the attending physician for them. In six of the 13, the right side of the body was involved. Two of the right-sided patients were aphasic but none of the left-sided ones were. Hospitalization varied from 12 to 58 days with an average of 25 days.

Turning to Table 4, we note that 11 of the 13 patients were discharged from the hospital at the time of this report, and that *all of them* (100 per cent) *went back into their own homes. None required nursing home referrals.* Two patients were still hospitalized. Regarding activities of daily living, five (45 per cent) were entirely independent; six (55 per cent) were partly dependent. None were dependent. Finally, regarding vocational goals, four (36 per cent) of the patients were employed, and seven (64 per cent) were not.

TABLE 4

WEST JERSEY HOSPITAL

	Number	Per Cent
Discharged to home	11	100
Discharged to nursing home	-	
Still hospitalized	2	
Activities of daily living		
Independent	5	45
Partly Independent	6	55
Dependent		- -
Returned to work or household duties	4	36
Did not so return	7	64

Table 5 shows that a total of 61 patients were accepted in the six months' period. Of these, 32 survived and are being followed. Overall mortality rate for the group was 41 per cent. Four patients were withdrawn.

TABLE 5

BOTH HOSPITALS

	Number	Per Cent
Patients accepted	61	100
Patients survived and followed	32	53
Patients expired	25	41
Patients withdrawn	4	6
Of 32 patients survived:		
Still hospitalized	6	19
Discharged from the hospitals	26	81
Of 26 patients discharged:		
Discharged to home	22	85
Discharged to nursing home	4	15
Activities of daily living (26 patients)		
Independent	12	46
Partly Independent	13	50
Dependent	1	4
Vocational placement (26 patients)		
Working	10	38
Not working	16	62

Of the surviving 32 patients, six (19 per cent) are still in the hospital, and 26 (81 per cent) have been discharged. It is interesting to note that of the 26 discharged, 22 (85 per cent) have returned to their homes, and only four (15 per cent) have gone to nursing homes. Of this same group of 26 patients, we note further that 12 (46 per cent) are completely independent, 13 (50 per cent) are partly dependent, and only one (4 per cent) is completely dependent. Finally, we find that 10 (38 per cent) of the 26 patients discharged are vocationally rehabilitated, and 16 (62 per cent) are not.

SUMMARY

1. This is a preliminary report on the Camden County Demonstration Stroke Project, which was underwritten in part by the Division of Chronic Illness Control of the New Jersey State Department of Health in coop-

eration with West Jersey and Cooper Hospitals, of Camden, New Jersey.

2. The team was directed by the medical director, using personnel and facilities already present in the community and at the two hospitals. The program included the early treatment of the hemiplegic patient in the general hospital and continued home and outpatient treatment by physical, occupational, speech therapists, and visiting nurses as indicated, following discharge from the hospital.

3. Through this program, the great majority of the patients were discharged to their homes. Most of these are now able to care for themselves; some of them could return to work.

4. This preliminary report demonstrates that it is both feasible and desirable to treat hemiplegic patients early and intensively, and that the salvage rate is gratifying.

340 West End Road (Dr. Florin)

BIBLIOGRAPHY

1. Lowenthal, A., Tobis, H. and Howard, B.: Archives of Physical Medicine, 40:256 (May 1959).

2. Public Health Service Publication No. 596, *Strike Back at Stroke,* U. S. Government Printing Office, Washington, 1958.

3. Rosenthal, A. M.: American Journal of Physical Medicine; *in press.*

Reasonable Care

A court in New York recently held a physician liable for the breaking of a hypodermic needle inserted for the purpose of administering an intramuscular injection of procaine. The question of the physician's negligence was submitted to the jury without the usual requirement that there be expert testimony to show want of the requisite "knowledge and skill" on the part of the physician.

The Court pointed out "that there could be instances of negligence on the part of the doctor where the results may be of such a nature as to warrant the inference of want of care from the testimony of laymen, so that the question does not require special knowledge or skill but is within the experience and observations of the jurors themselves from which they may draw their own conclusions."

The jury was instructed that the mere fact that the needle broke did not in and of itself establish negligence, but that they could find the physician liable only if they found such negligence in the maintenance, care, or use of the needle from the time of its purchase by him up to and including the time of the injection that caused it to break.

Evidence was produced to show that the physician had last purchased infiltration needles fourteen months before the injection in question. During these fourteen months he had purchased medications used in intramuscular infiltrations in quantities indicating that he had administered more than 1,000 injections of average doses. There was also testimony by a medical expert limited generally to the methods and meticulous care required in properly washing, cleaning, drying, and periodically testing needles of this type to permit their safe re-use.

The Court observed that "the jury could reasonably infer that these dozen needles had been re-used so excessively as to weaken them, even if proper care was taken, and in light of the expert testimony concerning the necessity and reason for strict maintenance standards, that they had been rendered dangerous for further use."

It went on to say " . . . in this case, the jury was warranted in holding the doctor liable for injury to his patient resulting not from want of requisite knowledge and skill but from the omission to exercise reasonable care within the experience and judgment of the jurors themselves."

LeRoy Homer, M.D.

Woodbridge

Methdilazine Intoxication

Any drug potent enough to be effective is potent enough to have side effects. Modern tranquilizers can be used with suicidal intent. Doctor Homer's article points out one such case and spells out the necessary management.

Many clinically effective antihistaminic drugs[1] have been developed since Halpern's investigations[2] of the properties of promethazine. One of the more recently introduced phenothiazine derivative antihistaminics is methdilazine. This is 10-(1-methyl-3-pyrroidyl methyl) phenothiazine. It was first synthesized in the Mead Johnson Research Center. This compound was reported[3] to be an effective histamine antagonist, a serotonin antagonist, to have anti-shock protective properties and to tend to reduce capillary permeability in experimental animal studies. Methdilazine has been cited[4] as clinically effective as an antihistaminic agent[5] with a small incidence of side effects.[6] In the usual clinical dosage, drowsiness has been reported in 10 per cent[5] to 20 per cent[6] of patients receiving it. Howell[7] reports one patient who ingested 120 milligrams of methdilazine at one dose without incidence.

Following is a report of a patient who attempted suicide by swallowing 280 milligrams of methdilazine.

A 44-year old man was brought to the emergency room of Perth Amboy General Hospital after ingestion of an unknown quantity of an unknown drug.

He was a stocky, well-built, well-nourished man. At admission he was restless but shortly thereafter, he became comatose. He was slightly cyanotic and he was vomiting coffeeground-appearing vomitus. Heart rate was rapid and regular; respirations were stertorous and wet with retraction at the suprasternal notch on inspiration. The abdomen was soft. No organs or masses were palpable. The extremities were flaccid and deep tendon reflexes could not be elicited.

Rectal temperature was 98; the pulse was 106; the respirations 28. Blood pressure was 160/90.

Hemoglobin was 15 Grams. The white cell count was 26,500 with 96 per cent neutrophiles; 3 per cent lymphocytes, and 1 per cent monocytes. Blood sugar was 100. Urea nitrogen was 5.1. The carbon dioxide combining power was 43 volumes per 100. The potassium was 3.2 milliequivalents and the sodium 144 milliequivalents per liter. The urine (catheterized specimen) gave a negative test for sugar and albumin; the sediment contained 1 to 3 white cells, 30 to 40 red cells and a few hyaline and granular casts per high-power field. The electrocardiographic tracing was normal except for sinus tachycardia.

Shortly after admission to the hospital, he received intramuscularly 2 cubic centimeters of meralluride. A Levine tube was placed through the nares into the stomach and continuous gastric suction was instituted. A continuous intravenous infusion of 5 per cent glucose in water alternating with 5 per cent glucose in normal saline was started and a Foley catheter was inserted into the bladder. He was given one Gram of caffeine sodium benzoate intramuscularly at that time and every two hours therafter until he became responsive.

Two hours after admission, he was noted to have edema of the tongue which interfered with respirations. He was, accordingly, given 0.5 cubic centimeters of 1-to-1000 epinephrin subcutaneously and 25 milligrams of prednisolone was administered rapidly intravenously. Another 25 milligrams were added to the liter of infusion solution which he was then receiving. Respirations remained labored

and obstructive in character. Nine hours after admission a tracheotomy was performed. By the end of the twelfth hour after admission, he had become responsive to stimuli.

On the second hospital day he was responsive, intermittently restless and partly disoriented. The gastric aspirate on this day continued to have its coffee-ground appearance. By the morning of the third hospital day he showed marked improvement, was completely oriented and the gastric aspirate had a normal, clear green appearance. The Levine tube was removed and the intravenous fluids were discontinued. At this time, we ascertained that he had been given a prescription for fifty tablets, each containing eight milligrams of methdilazine for treatment of rectal itching and that he had ingested 35 of these tablets at one time.

Though his temperature was normal on admission, he developed fever within the next few hours. Therapy with a penicillin-streptomycin combination was started and continued for nine days—by which time he had been afebrile for 24 hours. The tracheotomy tube was removed on the eighth hospital day and the tracheotomy incision was surgically closed on the twelfth hospital day.

On the eighth hospital day, he had a hemoglobin of 13.4 Grams, a white cell count of 8,450 with 60 per cent neutrophiles, 37 per cent lymphocytes and 3 per cent monocytes. He was discharged from the hospital 13 days after admission.

Methdilazine is completely absorbed from the intestinal tract and peak tissue levels are reached 30 minutes after oral ingestion. It is rapidly cleared from the blood stream and deposited in the tissues from which it is relatively slowly cleared.[8] Experimentally, methdilazine has a low order of toxicity. The LD_{50} for mice was 225 milligrams per kilogram; for rabbits 17.3 milligrams per kilogram and for dogs about 20 milligrams per kilogram. Hemograms in rats in chronic toxicity studies failed to show any significant changes. No histopathologic lesions were noted[9] in animals in chronic toxicity studies. Prostration, depression, labored respirations, clonic convulsions and sometimes complete hypnosis occurred in lethal doses in all species. Sub-lethal doses produced mainly depression.[3] Methdilazine has definite hypothermic effect in normal rats. In common with many other phenothiazine-containing compounds, methdilazine is an effective potentiator of barbiturates, ethyl alcohol and certain analgesics such as morphine, meperidine and aspirin.[3]

In the patient here presented, a dose of four milligrams per kilogram caused severe central nervous system depression, labored respiration, respiratory tract obstruction (due to edema of the tongue and laryngeal structures) and gastric irritation resulting in a hemorrhagic gastritis and vomiting. It is possible that the laryngeal edema was secondary to the irritation of the vomitus and not a direct action of the methdilazine. The treatment was supportive including stimulants, steroids, tracheotomy, parenteral fluids and antibiotics. A complete recovery was made.

SUMMARY

A PATIENT is presented who exhibited severe toxicity manifest by central nervous system depression, labored respiration, edema of the tongue and laryngeal structures and acute hemorrhagic gastritis following the ingestion of 280 milligrams of methdilazine. Full recovery followed supportive treatment.

150 Green Street

BIBLIOGRAPHY

1. Goodman, L. S. and Gilman, A.: *Pharmacologic Basis of Therapeutics.* New York, 1956. Mcmillan.

2. Halpern, B. N.: Archive internat. de Pharmacodyn., 68:339 (1942).

3. Lish, P. M., Albert, J. R., Peters, E. L. and Allen, L. E.: Archive internat. de Pharmacodyn., 129:77 (Dec.) 1960.

4. Compilation of Pharmacologic Data: Research Laboratories, Mead Johnson Company, Evansville, Indiana.

5. Crawford, L. V. and Grogan, F. T.: Journal of the Tennesse State Medical Association, 53:307 (1960).

6. Spoto, A. P., Jr. and Sieker, H. O.: Annals of Allergy, 18:761 (July) 1960.

7. Howell, C. M., Jr.: North Carolina Medical Journal, 21:194 (May) 1960.

8. Weikel, J. H., Jr., Wheeler, A. G. and Joiner, P. D.: Toxicology and Applied Pharmacology, 2:68 (January) 1960.

John J. Reilly, M.D.

Elizabeth

Hip Dysplasias in Children*

Much childhood and adult hip disability can be prevented if pediatricians and family doctors were alerted to the possibility of incipient hip dysplasia in infants.

Time is the essence of treatment in congenital dislocation of the hip. Differences in satisfactory end results are related to the age of discovery. Usually a satisfactory end result can be secured with simple and conservative means *if the diagnosis is made under one year of age*. The incidence of poor end results rises precipitously if diagnosis is made after one. The later a diagnosis is made, the poorer the end result and the more radical and intensive must be the treatment. The basic reason for the difference is the variable response of the structures involved in the young infant as compared to the older child. What is lost in the older infant is the ability of the acetabulum to mold, develop and deepen over the femoral head, once reduction is effected.

What are the dependable diagnostic criteria in the young infant from whom we cannot obtain any complaints or history? Unfortunately, the diagnostic criteria, commonly tabulated for congenital hips, really pertain to actual dislocation or subluxation and *not* to simple dysplasia. Unless there is actual spatial displacement (constantly or intermittently) these diagnostic criteria are of little value. Unless dislocation is present with dysplasia (or unless dislocation can be passively produced during examination) our diagnostic signs are valueless. They all depend upon an actual or passively produced displacement of the femoral head from the acetabulum. It is, therefore, imperative to distinguish between "congenital dysplasia" and "congenital dislocation or subluxation." There may exist some unclear concepts in the minds of us as physicians, as well as in the minds of the public about the difference. The two conditions are related in that congenital dislocation cannot logically exist without a shallow, dysplastic socket; but a dysplasia can exist without actual dislocation or subluxation. The potential for future dislocation exists if the socket does not deepen. Without x-ray we cannot make a diagnosis of a simple dysplasia unless there is actual displacement or subluxation. Occasionally, dysplasias are actually present in the young infant, which may go on to spontaneous development of a socket. Some acetabulae develop partial depth, sufficient to prevent actual future dislocation but may later in life (because of inadequate mechanical coverage of the femoral head by a full acetabular roof) become the prematurely worn or frequently labelled "osteoarthritic hips," which in actuality have their inception in mechanical deficiency from hip dysplasia. These can occasionally be seen in our 50 or 60 year olds and should be labelled "the hips of traumatic arthritis," from acetabular dysplasia of infancy, never completely developed either spontaneously or through treatment. These concepts have been long established. They bear reiteration occasionally for crystallization of our thoughts in this sphere.

---

*Presented May 15, 1962 at the Orthopedic Surgery Section of The Medical Society of New Jersey.

SYMPTOMS

WHAT are the common complaints on the part of the parent? What abnormalities are noted by the parent who presents the child to the physician for examination of a suspected hip disorder of this type? Most frequently the complaints are:

1. The infant's leg appears shorter.
2. The leg is not moved as freely as the other.
3. It tends to lie turned outward.
4. The skin folds are not even.
5. One of my other children or a close relative had a congenital dislocation of the hip and I am concerned that my child may have one too.

FINDINGS

The findings in the young infant are entirely dependent upon the presence of a frank dislocation, subluxation or the ability to produce it passively if not actually present. If some element of this is not present, the physical findings (which are dependent upon this) are obviously not present. I know of no specific finding, produced by the presence of a shallow socket *per se*, unless some displacement of soft tissue anomaly is present, preventing complete anatomic reduction of the femoral head.

These findings are, in order of importance:

1. *Limited abduction.* This, I believe, is the most important single finding in the young infant with congenital hip disease. I would belabor this point. If full abduction is not possible into a "frog position," either unilaterally or bilaterally, the hip should be investigated by x-ray. Other causes, such as a benign fetal contracture from position *in utero* or a spastic paraplegia from cerebral palsy might produce limitation of abduction; but even considering these, x-ray investigation is imperative for accurate diagnosis. The ability to abduct to a "full frog" position, in the otherwise normal infant, is contingent upon the femoral head reposing in the acetabulum. If it is not, the malposition in a paraarticular position prevents full "frogging." If all the other findings are normal and even x-ray appears normal, treatment with a simple abduction pillow splint or a bulky double diaper is in order until full abduction is obtained. This one sign is presumptive evidence of a congenital dislocation of the hip until otherwise proved, be it frank dislocation or a constricted isthmus of a capsule, or other obstructing redundant soft tissues in the socket.

2. *Gross shortening* may be present. This would be due to a proximally displaced femoral head, in the presence of otherwise normal findings in the extremity.

3. *Ortolani's click.* This (like the positive Bence-Jones protein in a multiple myeloma) is rarely obtainable. When present, however, it is pathognomonic of a dislocated or subluxed femoral head. It is caused by the femoral head slipping into a reduced position over the acetabular rim, producing a snap or "click."

4. *Asymmetrical or extra thigh creases* may be due to a displaced femoral head producing shortening and the soft tissue bunching up proximally. This produces high gluteal folds, high thigh folds or extra thigh folds, much in the same fashion as a pants leg folds over itself when an extremity is too short for it.

X-RAY FINDINGS

IN GENERAL, simple AP and "frog" x-rays reveal adequate diagnostic information. Gross interpretation of the films and notation of inadequacies of the acetabulum or disturbance of spatial relationships are usually adequate. In problem cases, where an unusual situation exists, stereoscopic films, tomography or oblique views may be helpful. Occasionally, arthrography has also been recommended as a diagnostic aid, although I have had no personal experience with it. Where borderline changes are present on the plain film, the use of various aids, drawn on the films are helpful.

1. Hilgenreiner, in 1925, described a diagrammatic method of ascertaining whether an acetabulum were deficient. He also could ascertain from this whether displacement of the femoral head was present. The Y-line is drawn across the triradiate cartilages. The H-line is drawn from the Y-line down to the superior limit of the diaphysis. The D-line is drawn across from the inner margin of the acetabulum to the H-line. These lines help to indicate displacements. The angle formed by the acetabular roof should be no more than 25 degrees. If the obliquity is over this, a definite dysplasia exists.

2. Wiberg devised the C-E angle as a diagrammatic aid. A line is drawn from the center of the femoral head to the lateral edge of the acetabulum

and the vertical line is drawn from the same starting point. The angle is diminished in the abnormal hip when the acetabular roof is underdeveloped or when the femoral head is displaced laterally. The angle should be no less than 15 degrees. Over 20 degrees is always normal.

3. Ombrédanne presented another diagrammatic aid in congenital hip dislocation. His method consisted of dropping a vertical line from the lateral margin of the acetabulum. If the ossification center or the projected position of this is on or outside of this line, subluxation or dislocation exist. It should be noted, incidentally, that the development of the ossification center of the epiphysis is usually retarded as compared to the normal side.

4. Kohler's tear drop sign has also been described as an aid.

It should be noted on x-ray that dislocation is diagnosed only when the femoral head actually leaves the confines of the acetabulum. Partial displacements are termed subluxations.

TREATMENT

TREATMENT can be divided as to age or the various states of the problem.

1. *Where simple acetabular inadequacy exists* with no displacement, under one year of life, treatment can be termed "prophylactic." It aims at preventing dislocation and encouraging development of the acetabulum. It consists of using any one of the many types of abduction splints. These range from the simple bulky diaper to the metallic splint or cast. My personal choice is a common Frejka pillow splint. The aim is to secure and maintain a "frog" position at the lower extremities. Keeping the femoral head in the acetabulum encourages development of the socket over the head. The pillow splint is inexpensive and effective in this age group. Commonly, where early subluxation exists and occasionally even with actual dislocation, after two to four weeks in a pillow splint, the extremity drops easily to a full "frog" position and the femoral head is maintained in the acetabulum. X-rays every six or eight weeks, where actual dislocation is not present (or once reduction is effected) is sufficient until an adequate socket is obtained. In the young infant (birth to nine months or one year) adequate depth will be seen within six months with regularity and frequently before this.

2. *Where subluxation exists* and the infant is under six months of age, I have frequently seen a fairly prompt reduction with the use of the pillow splint. Where the child is over nine to twelve months of age, a more vigorous approach is usually necessary.

3. *Where subluxation or dislocation exist after one year of age,* but displacement is not marked, very gentle manipulation should be tried. Vigorous, rough manipulation with snapping and crunching of the femoral head in and out of the acetabulum under anesthesia is not in order. Many times, with the child well relaxed under general anesthesia, the hip can be gently lifted out to a position of full abduction and reduction effected easily.

4. *If this is not possible,* plaster skeletal or skin traction may be applied until the soft tissue contractures stretch; and then reduction can be secured with gentleness. Gentleness is the important factor in closed reductions, in preventing aseptic necrosis.

5. *If reduction is felt to be present* and acetabular development does not ensue in four to six months (or where reduction is impossible by closed methods) then open reduction is in order. A capsular constriction, elongated ligamentum teres or some other soft tissue anomaly may prevail. This may render closed reduction methods ineffective. *Open reduction* is considered by some to be a primary treatment of choice, with the hope that the incidence of aseptic necrosis is less than by closed treatment. Occasionally, this is followed by rotational osteotomy, correcting anteversion, obtaining a more favorable presentation and retention of the head in the acetabulum. If acetabular development does not ensue in six to nine months, after adequate reduction and retention, a shelf procedure is in order. Pelvic osteotomy with rotation of the acetabulum over the femoral head has been reported with favorable results. I have no personal experience with this.

COMPLICATIONS

1. Aseptic necrosis of the capital femoral epiphysis is an occasional sequel to either open or closed treatment. When it does arise, weight-bearing must be restricted until reossification occurs. The late end results will be directly related to the amount of ensuing deformity and incongruity of the femoral head in the socket.

2. Traumatic arthritis arises as a late end result from inadequate acetabular coverage or from aseptic necrosis. These hips, if not severely involved, will give pain-free service usually until the third or fourth decade, at about which time the stress of years of use will begin to tell. Pain is not common in a child with hip dysplasia, or even with frank dislocation. Pain is a later complication.

3. Shortening may occur from either persistent dislocation or epiphyseal damage and retardation in growth.

4. Shelf absorption will occasionally occur in a young child.

5. The presence of wound infection is a possibility in open reductions.

6. Plaster complication will occasionally occur.

LATE DISLOCATIONS

WHERE a child is over five years of age, I believe that attempt to reduce a frankly dislocated congenital hip is usually contraindicated and a salvage procedure (such as a shelf) should be elected.

CASE FINDING

WHAT can be done to pick up these mild dysplasias while they are still in a benign phase and the potential for a good hip is present? It is my feeling that nothing, short of routine x-ray survey, will enable us to pick up *all* these problems. Occasionally, even one survey, at a certain age group, may not suffice, since the status of acetabular development at birth may in no way indicate the status at one year of age, although commonly (once adequacy is present) future development of the acetabulum is assured. If adequate head coverage is present by the end of the first year, one can usually feel secure about the future growth and development of the socket with respect to congenital causes. In the younger infant, diagnosis may be difficult. In the older ambulatory child, diagnosis is usually simple and is evidenced by limp, positive Trendelenburg sign and shortening.

Further issues arise when considering such measures as routine x-ray survey in all infants. The question of radiation exposure for mass surveys, economic factors, facilities for such surveys and other problems arise. Is such an approach justified for the small additional incidence of benefit that would accrue to the population in view of the effort and expense involved? These questions are in the realm not only of the orthopedic surgeon but also of the radiologist, the geneticist and economist. In our present state of knowledge and diagnostic ability, I feel that we do miss a certain small group of this type of problem which produce some of our middle-aged hip cripples.

It would be helpful if on the follow-up well baby examinations by the family physician and the pediatrician, the child had his hips examined frequently during his first year of life. Occasionally, one of the diagnostic physical findings may be present and may cause the practitioner to think of possible hip dysplasia. If any of these suspicious physical findings are present, x-ray follow-up is imperative. As with all of medicine, persistent attention, adequate examination and background of knowledge with necessary, indicated follow-up laboratory or x-ray examinations continue to make the practice of medicine the art which it is and not a routine technical performance. It is my firm conviction that the physician is here to stay despite Univac.

222 Elizabeth Avenue

J. T. Noguera, M.D.
Asbury Park
F. Robert Haase, M.D.
Neptune

The Present-Day Status of Stapes Surgery*

Criteria for various types of surgery for otosclerosis are clearly spelled out in this practical paper.

Otosclerosis has been attacked with a multitude of surgical procedures. However, as the smoke of the initial confused battle clears, a strong and definite trend stands above the rest: total stapedectomy.

The modern phase of stapes surgery was initiated by Rosen [1] who champions the "graduated approach." This consists of trying mobilization of the stapes at the neck first, then at the footplate, after which an anterior crurotomy is performed; and if all fails, a total stapedectomy is done. Shea initiated stapedectomy and vein graft, which was the first highly effective surgical approach to otosclerosis. This is the technic most commonly used by him at present.

Schuknecht developed the use of the stainless steel wire prosthesis and the fatty connective tissue graft. This tissue is obtained from the ear lobe. It is readily available and easy to trim to size. Being soft, the graft molds itself well to the oval window niche. Schuknecht [2] feels that because of its body and thickness, it is safer than a thin graft, and particularly safer than Gelfoam.® The stainless steel wire prosthesis, once it is properly placed, will not dislodge and can be adapted more readily to any anatomic peculiarity encountered. At present he uses this method in all cases of otosclerosis.[2] His audiometric results are comparable to those of vein grafting.

Shambaugh uses anterior crurotomy in otosclerosis confined to the anterior end of the footplate. In more extensive cases he uses the wire and fat graft prosthesis. Occasionally he will transpose the posterior crus after doing an anterior crurotomy if there is a posterior focus of otosclerosis, or a fracture of the posterior crus. He prefers the anterior crurotomy because there is definitely less cochlear trauma and impairment of function as compared to stapedectomy. He states he has seen only three cases of further hearing loss of the cochlear type in over 400 patients operated on by anterior crurotomy with or without transposition of the posterior crus.[3] He reports that as the focus grows, the footplate is displaced posteriorly and wedged against the posterior lip of the oval window. After the anterior crurotomy and footplate osteotomy have been done, if the posterior segment is still fixed, it is gently pushed anteriorly thus dislodging it and restoring its free mobility.[4] Though it may have been wedged for a long time, the elastic membrane between the footplate and the oval window border apparently is not damaged. Bellucci [5] feels that refixation may be avoided after mobilization by pushing the footplate into the labyrinth for a very short distance with a polyethylene prosthesis.

---

*Read May 15, 1962 at the Annual Meeting of The Medical Society of New Jersey.

To accomplish this the "superstructure" of the stapes is removed, the distance between the footplate and the lenticular process is measured and a polyethylene prosthesis measuring a fraction of a millimeter more than this distance is inserted, then the footplate is mobilized. The footplate is thus pushed slightly below the level of the oval window. He states that if extreme care is not exercised to avoid any part of the edge of the footplate from touching the oval window, the chances of refixation are higher.

Farrior[6] developed the technic of crural repositioning, where the posterior crus is cut at its base, but left attached to the neck and incudostapedial joint. This attached crus is rotated inferiorly so that the footplate can be well visualized. An area of uninvolved footplate is then "mobilized" and the posterior crus rotated back to make contact with the mobilized fragment.

House[7] will shatter the footplate in cases of annular otosclerosis where all the margin of the footplate is involved, but the greater center area is not. He then places a strut from the incus resting directly on the fragmented footplate; or if there are relatively large defects between the fragments, he positions a piece of Gelfoam® over the fragments, and the strut rests on the Gelfoam®.

Tato,[8] from Argentina, devises a mucous membrane flap from the promontory, and slides it over the newly opened oval window, then places the strut between the incus and this pedicled graft.

In these approaches the prime consideration is the local pathology at the time of surgery. The relation between hormonal activity in the female and the activity of the process has to be taken into consideration. This relationship is clinically demonstrable in that pregnancy will make deafness worse; in the fact that the process is progressive from puberty to menopause, and that it tends to become static after menopause. In males this relation has not, to my knowledge, been demonstrated.

After I started doing mobilizations of the stapes in 1956, I noticed a definite tendency of the post-menopausal patients to maintain their hearing after a successful operation. Some of these patients would refix, and when they were re-operated with the additional help of the operating microscope, we found that the failures were due to extensive otosclerosis, or to fixation of one of the crurae to the walls of the niche of the oval window. I have, therefore, evolved criteria to guide me in the selection of the operative procedure.

If the patient is pre-menopausal a stapedectomy and vein graft are done. The only exception is a patient approaching menopause in whom the hearing curve has been static for at least two years. In these cases an anterior crurotomy procedure is performed if the local pathology and anatomy will permit it.

If the patient is post-menopausal an anterior crurotomy procedure is tried if the focus of otosclerosis does not involve more than the anterior third of the footplate, and if the niche of the oval window is wide so that the crurae of the stapes are well separated from them.

In males past the age of sixty, an anterior crurotomy procedure is done if the criteria above are met. Males who fall in this category, however, are rare. Usually the otosclerotic process includes much more than the anterior third of the footplate. The age of sixty as a dividing line is arbitrary.

In rare cases, anatomic difficulties may force us to utilize a procedure which may not be the one ideally indicated in that particular case. One patient with osteogenesis imperfecta comes to memory vividly to illustrate this point. Patients who survive childhood with this condition develop fixation of the footplate of the stapes. Whether this is otosclerosis or not has never been determined; but the end result is the same. This patient had an almost horizontal tympanic membrane, and at operation only the neck of the stapes could be visualized, as the footplate must have been well under the facial nerve and almost on the roof of the middle ear. Mobilization at the neck was attempted and the crurae fractured. Blindly (by the sensation of touch) the footplate was shattered and a polyethylene strut inserted between this area and the incus.

Hearing was restored from an average loss of 50 decibels to a 25 decibel average and has been maintained for two years. The opposite ear showed the same anatomic problem and the same sequence of events followed, with almost identical results.

After over 400 cases, I still find it difficult to evaluate accurately the extent of otosclerotic involvement of the footplate. Visualization of this structure is obstructed by the tendon of the stapedius muscle, the crurae of the stapes, the long process of the incus and sometimes an overhanging facial canal. I make a real effort to do an accurate evaluation in the patients previously mentioned as being candidate for a conservative procedure, for obviously if the extent of involvement is missed, the results will not be as expected. Once it is decided that an anterior crurotomy will be done, an osteotomy across the midportion of the footplate under 25 x magnification is performed with a chisel just using hand pressure. This osteotomy must be complete. It is done first in order to provide some yield to the posterior crus and thus avoid its fracture when the anterior crucrotomy is performed. A segment of the anterior crus is removed to prevent refixation. Several instruments have been devised just for this part of the operation but I have found that I can prevent fracture of the posterior crus most of the time by cutting the anterior crus at the junction of its distal and middle one-thirds with a Shea right angle footplate hook. By repeated rotations of the hook, microscopic chips are removed until the cut is completed. The fragment attached to the footplate is then fractured by pushing it at its junction to the footplate. If the posterior segment still does not move freely, it is gingerly pushed forward to disengage it from the posterior lip of the oval window, as suggested by Shambaugh.[4] Using this technic, we have not seen any further loss of hearing attributable to operative trauma. But, of course, the patients who are candidates for this operation are a minority. Most require stapedectomy and vein graft. In these cases, microscopic perfection is strived for to obtain the best results. These results are obtained if the vein graft is stretched neatly and then slightly invaginated into the oval window. It should be well adapted to the surrounding area from which all mucosa has been removed and perfect hemostasis obtained. It should not be in contact with the sides of the polyethylene strut. The strut should be just the right length to prevent it from getting loose if it is too short, or from pushing too much vein into the labyrinth if it is too long. The strut should not be in contact with any of the surrounding osseous structures.

To achieve this technically perfect result, we must first study the local anatomy and pathology after removal of the superstructure of the stapes. This work is definitely not for the surgeon in a hurry. After the surrounding mucosa has been removed and perfect hemostasis has been obtained, the vein graft is inserted and carefully tried in place. The adventitia of the vein should be carefully removed under the microscope before insertion. In this "dry run," it is determined if the vein is adequate in size and thickness, and whether it will be in contact with the polyethylene strut if the niche is narrow. Saucerization, if necessary, is done by means of the electrically driven burr. Because traumatized bone is more likely to grow back, saucerization is not done unless absolutely necessary. A very thick footplate should be thinned down by means of the electric burr, so that its fragmentation will be easily controlled. This will lessen the chance of a sudden thrust of a sharp pick into the labryrinth. Irrigation of the middle ear is carefully avoided (no matter what solution is used) as this will markedly increase the percentage of serous labyrinthitis, as shown by Shambaugh.[4] When the footplate is penetrated, only a Number 24 suction tip is utilized. Perilymph is suctioned only if it interferes with adequate visualization. In our cases the severity of dizziness, and the time required for the labyrinth to recover from the operative trauma, as demonstrated by hearing tests, is inversely proportional to the amount of sucking necessary at the time of surgery. If no suctioning is done, mild dizziness does not last over 24 hours.

COMPLICATIONS

Even if all these precautions are taken, complications do occur. The most feared one is infection of the middle ear, at which time thoughts of a purulent labyrinthitis and meningitis always cross the surgeon's mind. It is remarkable, however, how quicky the vein seals the oval window. We have seen only one case where infection produced permanent damage to the frequencies 250 and 500 as demonstrated by bone conduction studies, while the rest of the higher frequencies were not affected at all.

The commonest complication is cochlear damage, which most often affects the 4000 frequency. This loss is normally not detected by the patient, as the conversational frequencies are the ones important to him. However, cochlear damage may be severe, and is usually delayed following stapedectomy. The pathogenesis of this process has not been established. It is logical to assume, though, that the severity of this damage will be in direct proportion to the mechanical, chemical and bacterial trauma to which the labyrinth is submitted. This is why the incidence of such cochlear damage in the conservative procedures is very low.

Other less frequent complications include sudden flooding of the middle ear with cerebrospinal fluid.[9]

Development of meningitis through a labyrinthine fistula has also been reported after an otitis media. In this case, the surgeon used Gelfoam® over the oval window as the only sealing substance.

Occasionally there is an overhanging facial nerve that impairs visualization of the footplate. Contrary to the usual teaching, there is a dehisence in the facial canal in 40 to 50 per cent of all patients. I am sure this dehisence closes in most cases of chronic suppuration, with which we were more in contact previous to the era of stapes surgery. The overhanging facial nerve, not totally covered by bone, may be pushed inadvertently with the instruments during the surgery and a temporary facial palsy will occur.

Dislocations of the ossicular chain have been reported, as well as dislodgment of the plastic prosthesis. Erosions of the tip of the long process of the incus have occurred, usually when a wire prosthesis was put too tightly on this area.

Perforations of the tympanic membrane may occur usually in the posterior-superior quadrant of this structure.

The most discouraging complication is closure of the oval window by newly formed bone. It is particularly discouraging to the patient, who has been able to hear again for three or four months, and then notices that his hearing begins to drop until it returns to the preoperative curve. Closure is more frequent in advanced cases where much drilling is necessary, especially if the patient is young. Reoperation in these cases, to create another oval window, always meets with failure. These ears are candidates for the classical fenestration of the lateral semicircular canal.

Remarkable progress has been made in this phase of otologic surgery, but many questions still remain unanswered. We hope that as further experience is developed and technics are refined, an opportunity to hear again close to 100 per cent will be offered to these unfortunate patients.

601 Grand Avenue

BIBLIOGRAPHY

1. Rosen, S.: Journal of the American Medical Association, 178:1144 (December 1961).

2. Personal communication to the author.

3. Shambaugh, G. E., Jr.: By-Pass Surgical Technics in Stapes Surgery. Academy of Medicine of New Jersey and Academy of Ophthalmology and Otolaryngology of N. J., Newark, N. J. (April 1962).

4. Shambaugh, G. E., Jr.: Two-Year End Results after Stapes Mobilization, International Congress of Surgeons, New York (September 1959).

5. Bellucci, R. J.: AMA Archives of Otolaryngology, 73:513 (May 1961).

6. Farrior, J. B.: AMA Archives of Otolaryngology, 71:443 (March 1960).

7. House, H. P.: AMA Archives of Otolaryngology, 71:926 (June 1960).

8. Tato, J. M.: *Laryngoscope*, 70:1603 (1960).

9. Ward, P. H.: AMA Archives of Otolaryngology, 74:399 (October 1961).

Joseph A. Cox, M.D.

Elizabeth

Anesthetic Problems in the Operating Room in Chest Injury Cases*

Proper choice and administration of anesthesia may be a life or death matter in chest surgery.

When a patient with a serious chest injury is brought to the operating room for definitive surgery, the anesthesiologist is often confronted with major physiologic derangements of the pulmonary and cardiovascular systems. These compound the regular hazards of emergency surgery and those associated with injuries to other parts of the body. Any of these factors alone poses problems. Collectively, they demand immediate measures, to avert a fatal outcome. I here consider the general principles of anesthetic management of emergency cases, in conjunction with specific considerations as they apply to chest injury cases.

First, a pre-anesthetic evaluation must be made. Circumstances may demand that this be brief, but it should never be omitted. The following items should be ascertained.

(1) The status of blood pressure, pulse rate, and depth and rate of respirations
(2) The extent of injury, the severity of the chest trauma, and injuries to other body systems
(3) Examination of the patient

As time permits, the following important items should be checked:

(I) Pre-existing diseases, such as coronary, diabetes, tuberculosis, and so on
(II) Drug allergies
(III) Recent drug therapy, especially cortisone, antihypertensive agents, and insulin
(IV) Recent ingestion of fluids, food or alcohol
(V) Emergency medication for pain or other reason, administered since injury

Such information furnishes a physiological base line, with which the effectiveness of remedial measures may be compared. It provides an intelligent approach to the proper interpretation of subsequent changes, whether for better or worse. It also affords the opportunity to prescribe for specific needs which might have been overlooked. Without such pertinent information, otherwise beneficial technics and treatment may be adversely affected by the unknown factors.

In some instances, none of the past history is obtainable. These are the times that emphasize the need for a medical identification card to be carried at all times. Such a card would tell us, for example, what type blood the patient has, whether he has had recent immunizations against tetanus; it would list allergies to horse serum, morphine or certain antibiotics; would indicate if he had been taking cortisone for arthritis, insulin for diabetes, reserpine for hypertension, disulfiran for alcoholism or anticoagulants following a recent myocardial infarction. The importance of such information cannot be overemphasized.

Having established a proper knowledge of the injured patient, to the extent possible, the

*Presented May 15, 1962 at the Annual Meeting of The Medical Society of New Jersey. This work is from the St. Barnabas Medical Center in Newark.

pre-medication to be prescribed must next be decided. For pre-medication three groups of drugs† may be given. Not all three groups are to be routinely prescribed; but rather that one or another alone, or in various combinations, do possess certain advantages.

In the *belladonna* group, atropine is routinely prescribed to diminish the secretory activity of the glands lining the upper and lower respiratory tract. This affords protection against untoward reflexes mediated through the vagus nerve. One of the entities which must be remembered when prescribing atropine, is glaucoma. As a general rule belladonna drugs should be avoided in these patients. However, ophthalmologists agree that a reduced dose may be administered when so indicated, provided eye drops, to produce miosis, are instilled pre- and postoperatively.

Among *opiates*, morphine and merperidine are most commonly given for pain. While the chest injury patient is usually in severe pain, he may have respiratory embarrassment. While narcotics do depress respirations, pain increases the patient's tolerance for an opiate. These facts emphasize the importance of protecting the patient's ventilatory capabilities, such as they may be, while alleviating his suffering. It is better to err on the side of a lesser dose, which can be augmented, than to order a larger dose than is required.

In the *barbiturate* and *ataractic* groups, such drugs as secobarbital or pentobarbital, as well as chlorpromazine and other phenothiazines are usually prescribed pre-operatively in *elective* surgery, to allay anxiety and apprehension. They are seldom appropriate to this type of *emergency* surgery. However, in certain instances, they are useful. In the absence of shock (if a limited surgical procedure under local anesthesia is contemplated) they could be used if respirations are not depressed. In the presence of hemorrhagic shock, Collins[1] has reported the beneficial effects of small doses of chlorpromazine on the integrity of the microcirculation, particularly with reference to the preservation of kidney function, as well as its anti-stress effects.

† (1) Belladonna series; (2) Opiates; (3) Sedatives.

In preparation for the administration of anesthesia, measures to correct the circulatory and ventilatory deficits must be undertaken immediately. While the surgeon orders and institutes parenteral fluid, expander or blood therapy, the anesthesiologist provides augmentation of respiratory function. In this regard, oxygen by mask will benefit most of these patients; but it should be remembered that positive pressure oxygen may actually cause further embarrassment to a patient with tension pneumothorax, since more gases under pressure would be delivered to the affected side. Likewise, it should be remembered that where there is a large sucking wound of the chest due to the interruption of the thoracic cage, this must be covered and sealed temporarily, to prevent paradoxical respirations. In blast injuries, pulmonary ventilation is improved by the administration of 50 per cent glucose or serum albumin intravenously to relieve the interstitial edema occurring in this condition, thereby providing adequate exchange of oxygen and carbon dioxide across the alveolar membrane.

The types and technics of anesthesia applicable to chest injury cases will vary according to the three following factors:

(1) The severity of the injury and resultant condition of the patient.
(2) The urgency, type and length of surgery contemplated.
(3) The presence of other influencing conditions.

Local anesthesia may be indicated under certain circumstances, such as thoracentesis, insertion of a tube for underwater drainage or the performance of a tracheostomy.

General anesthesia is most commonly indicated. This necessitates the utilization of the endotracheal technic to maintain complete control of airway patency, in addition to guarding against aspiration of any gastric contents may be present in such an emergency case. In fact, it may be advantageous in some instances to instill a topical anesthetic into the larynx and trachea and intubate the patient before induction of general anesthesia.

Selection of the appropriate general anesthetic agent depends upon availability, experience of the anesthetist, and the special proper-

ties of the agent. A few anesthetic drug properties may be mentioned to illustrate this point. Sodium pentothal is widely used today, but it is such a potent respiratory and circulatory depressant, that it is interdicted in the presence of shock. When hypotension is present or imminent, cyclopropane is a valuable agent. When hemorrhagic shock is not a factor, the smoothness and rapidity of induction with pentothal attest to its general usefulness. Recently, halothane* has gained favor and its potency, spasmolytic effect and lack of stimulation of secretions, speak in its behalf. The advantages and disadvantages of other agents will not be discussed for reasons of time.

Management of the patient during anesthesia and surgery should be in keeping with the dictates of proper physiologic and pharmacologic balance. In addition, it may be noted that the utilization of a mechanical ventilator, such as the Bird® Mark IV and VIII, serves a most useful purpose in such emergency thoracic cases. It affords a readily adjustable and effective means of providing adequate ventilation. Utilization of such a ventilator by the fixed volume technic *via* a tracheostomy, provides the internal pneumatic stabilization in crushed chest injuries that is described in detail by Morsch, Benson, *et al.*[2]

In conclusion, I wish to emphasize the necessity for teamwork and common understanding of problems between the thoracic surgeon and anesthesiologist. In this manner the patient's condition will be efficiently and effectively remedied and the high standards of clinical practice and patient care preserved.

*Halothane is usually identified by its Ayerst tradename of Fluothane®.

158 Stiles Street

Blood Pressure and Longevity

Even modest elevation of blood pressure can have adverse effects on length of life, according to observation of applications for life insurance. This is one of the conclusions from material presented in a pamphlet *Blood Pressure: Insurance Experience and Its Implications*, just published by Metropolitan Life Insurance Company.

The pamphlet condenses, in graphic form, major findings of comprehensive studies on blood pressure by the Society of Actuaries and Metropolitan. Included is the combined experience of 26 life insurance companies covering 4,000,000 persons accepted for life insurance, supplemented by special investigations of Metropolitan's data.

Highlighted in the work is the serious effect of higher blood pressures. Mortality figures show that a significant rise in deaths is associated with even a slight rise of blood pressure. This conclusion is questioned by many physicians. With relatively moderate elevation of blood pressure, mortality was 50 per cent or more above that of standard insured risks, and with marked elevation, even short of serious hypertensive levels, the mortality was two to five times that of standard risks. The effects of increasing blood pressure were more serious in men than in women.

The material also includes up-to-date figures on average blood pressures and the variations according to sex, age and body weight. This underscores the necessity for regular health supervision among persons with moderate or even slight elevations of blood pressure.

The pamphlet is available to physicians from Metropolitan's Health and Welfare Division, 1 Madison Avenue, New York 10, N.Y.

The charts in this pamphlet were reproduced from an exhibit recently awarded a top prize at the meeting of the American Industrial Health Conference.

Jack Chernus, M.D.

East Orange

New Frontiers in Psychosomatic Medicine

Knowing that disease has an emotional component is not enough. The physician should seek to understand how this component is shunted along the somatic rather than the anxiety channel.

Despite the voluminous literature on psychosomatic medicine, and the attention paid to it in medical seminars and classrooms, there is still widespread misunderstanding as to fundamental concepts. Too often it is suggested that every illness has an emotional component which must be recognized and treated. A more sophisticated observation is to the effect that this psychologic facet may influence the course of the disease process. I do not challenge the truth of these concepts, nor the value of their being accepted by the profession. But the scientific attitude demands that truth be assiduously explored to the limits of our capacity.

In this spirit, I suggest that there is sufficient evidence for understanding psychosomatic illness in a far more reaching frame of reference. Briefly (and over-simplified) psychosomatic illness is a disease of tissue, or derangement of physiologic function, which plays a key role in solving an intense, unconscious emotional conflict. Although individual organs are quasi-destructively assaulted by the illness, the organism as a whole is preserved from psychic disintegration by the illness. To grasp this "concept of preferentiality," it is useful to bear in mind the familiar expression—"I'd rather die than"—(usually the alternative is some painful or embarrassing effect). A lesser version of the same formula is the equally familiar—"I'd rather take a beating than"—.

Of equal importance in understanding psychosomatic disease is the concept of "specificity." A conflict does not seek resolution by a random choice of tissue pathology, but rather by a specific pairing of *this* conflict with *this* illness. The following illustrations are deliberately brief and sketchy, because I am concerned only with widening the conceptual understanding of psychosomatic illness and not an exposition of detailed-treatment regimens.

CASE ONE

John is a 37-year old, married, electronics technician. His family, childhood and adolescent-health history are not remarkable. During military service he began having "stomach trouble." Following discharge from service he worked hard, taking advantage of training benefits under the "G.I. Bill" and elevated himself from semi-skilled class to a skilled technician. He enjoys a compatible married life. He landed a job with a large corporation, and vividly describes his mixed feelings on that job. The management of the company is tolerant with their scientific personnel to such a point of laxity that "you could spend days in the company library, actually snoozing; but if you have a book in front of your face, no one says a thing to you."

He expressed vague disquietude over this laxity, because he is ambitious to get ahead. He fears

that such ground rules may work to his disadvantage. "I do my share goofing, but I don't like the situation at all."

He went on to say that his wife is a very amiable woman who makes no demands on him. They have a child and he is restless under his own challenge to get on in life, and provide a decent standard of living for his family. This restlessness is most marked on weekends, when he slumps in a chair, quite dispirited, because he has no opportunity to do anything "constructive." He doesn't enjoy his leisure, yet cannot seem to find opportunity for work, despite some opportunities for overtime and advanced study. When extra demands are made on him by the company, he "works like a beaver" and gets complimentary pats on the back from his superiors.

It is at this time in his life that his stomach trouble returned; and clinical investigation showed a typical duodenal ulcer. Because of his ulcer, his work career is marked by periods of intense industriousness and productivity, alternating with periods of home-bound disability, and total unproductiveness. A good deal of relevant material emerged in the treatment sessions, which I do not think it is useful to detail. However, the material justifies this formulation of the patient's unconscious conflict; and since it is rooted in his first year or so of life, of his "character." John has a very strong (unconscious) longing for the "oral" satisfaction of infancy—lying in his crib, sucking milk from a nipple (breast) and feeling supremely omnipotent, as well as sublimely approved of and loved by the object (mother). At the same time, however, there is an enormous feeling of guilt over this state of affairs which drives him to repress the wish.

It is as if the infant enjoyed an ultimate heaven of sucking and being loved, only to be cast out of heaven by the appearance of a horrifying guilt that in satisfying this "orality," he is "eating up" (and destroying) the cherished love object. Thus, the wish for orality (to which his stomach lining happily responds with abundant gastric juice) has to be rigidly repressed. The forced introduction of the opposite (conscious) wish to work hard and make money that feeds others—is well suited to the purpose of repression.

John is struggling with the same conflict today. Insofar as he has an easy job with a large corporation where "he does his share of goofing," he is satisfying this urge; but the enormous guilt comes into play at the same time which threatens him with psychic disintegration. The ulcer "rescues" him from this conflict—suffering as he does from pain and the attendant danger of bleeding, and so forth, he can take to his "crib," drink milk every hour, without guilt (who could point a finger of scorn at him?) or loss of approval.

CASE TWO

Caroline, a nine-year old girl, had developed lower-abdominal pain, and frequent bloody stools, at the age of six. Since then she has run the typical course of ulcerative colitis—periods of dangerous emaciation, bloody stools, or blood mixed with mucus, as many as fifteen in a day, alternating with periods of moderate improvement. She is a sweet, dainty child who bears her dreadful illness with stoic nobility. During her worse times her principal anguish is that she may not be able to console her grieving mother.

The psychodynamic origin of her illness can best be elucidated from the mother's history. The latter is an arresting figure—highly intelligent, forceful and ambitious. Before she was married, she accomplished miracles in the way of securing for herself a good education, despite the fact that she came from a poor family that discouraged such ambitions. Next, she achieved outstanding success in her work in a Government office. She applied the same zeal and married a much-better-than-average man. She tried hard to be a "perfect mother" with her first child but felt that she had failed noticeably. With her second child, our patient, she redoubled her efforts to achieve ultimate personal success by rearing a "perfect child."

The mother revealed her own background in many tearful sessions. She was an only child in a troubled home. She was severely constipated and received hateful enemas frequently. All her life she agonized at the sight of her ailing, slowly-dying mother, and her faithless father. She felt intense guilt, recalling how she was frequently called "bad," how her mother often wailed, "you are killing me," and how driven she was to expiate and "make good." She regarded herself as very plain, and put all her hope in worldly success rather than in romantic success. Though she had an outstanding husband and an upper-middle-class social situation, she was vaguely restless and unhappy even before the advent of Caroline's colitis. Since then, she has felt utterly crushed, and sees no use to live—"I can't go on, watching her slowly die."

She stated that Caroline was an average infant, but was constipated, like herself. They had an intense closeness from the first; she was an intuitive, bright child who, the mother was sure, could sense every subtle shade of feeling between them. "We are still together even in this horror. She has the bleeding, and smiles bravely, and I'm dying with anguish over her sickness."

At the age of five Caroline began to have recurrent nightmares of robbers. The mother spent frequent evenings and nights in Caroline's bed to assuage her terror. The night the illness began followed a day in which her mother had several times scolded her. "I know she felt guilty; I know all about guilt from my own life with my mother; I know how guilty some children can get." She then recalled that about one week earlier, she had

drunk some beer and suddenly began to cry. Caroline came running to her in great misery and pleaded over and over—"Mommy, what did I do?"

Even from this brief sketch, we can formulate a reasonable understanding of her illness in the psychosomatic frame of reference. Caroline is in an absolute emotional symbiosis with this conflicted mother. Being a highly sensitive and intuitive child, she developed, early in life, an intense capacity to feel guilty over hurting or disappointing her mother, coupled with an equally intense urgency to expiate and make amends—to restore mother's happy feelings (and thus her own—symbiotically). All this happened at a time when the principal activity between mother and child is the urging of the former that the child "make duty" on the toilet, and the child's principal resource to make mother happy is the production of stools.

The nightmares of robbers at the age of five suggests that by this time the child was unconsciously preoccupied with sexual fantasies, and was probably in conflict with mother on this level (mother was really disappointed in her own life as a woman, and held high hopes for Caroline in this area). However, the attempted resolution of the conflict went back to an earlier time, when mother was so concerned about wiping out the haunting memory of her own "wickedness" by rearing a perfect child. Thus, Caroline was developing along her own path, when suddenly she was smitten with great guilt that she was hurting and disappointing her mother. Through her colitis she could stave off this unbearable crime and make amends through stools. She also achieved the peace of mind of the guilty—"better me than you."

CASE THREE

Mrs. Mildred, age 36, became pregnant for the second time. Her health had been good, except for asthma during six years in her late teens and early adulthood. She married at the age of 29, and had one uneventful pregnancy at 31. Now she began to cough and wheeze slightly, but wasn't much concerned, thinking this was a mild recurrence of her asthma. However, a routine chest x-ray in the fifth month revealed a cavity in the right upper lobe. Sputum was positive. After several consultations between the husband, patient, obstetrician and internist, it was decided that spontaneous, full-term delivery should be planned, and if successful, the mother should then enter a tuberculosis sanitarium, while the baby would be cared for by a foster mother, until the patient was non-infectious. Then she could take her child and care for it herself.

Everything went optimally. She was delivered of a healthy girl, who was immediately placed with a loving, capable foster mother. The patient entered a sanitarium where she underwent standard treatment for two years. Then she came home and continued successful out-patient treatment for another two years. At the end of that time her internist pronounced her quite well and non-infectious. There was a tearful-emotional scene for all, as the patient took her daughter home, to live with her "real Mommy." She was now four years old and "not a baby any more." At first the mother was quietly happy. Soon she became depressed and was referred for psychiatric consultation and treatment.

How does this case fit in with our presentation? Apparently, it does not at all, unless one raises the broad question of why female urban dwellers, in healthy adulthood, without being exposed to unusual stress or source of infection, suddenly develop active tuberculosis in pregnancy. Of course, it may be argued that pregnancy is a stress, and that tuberculosis is one of its hazards. This is precisely the point: whether this tuberculogenic stress of pregnancy is to be accepted as a purely physical event, which defies precise physiologic explanation; or is it a psychosomatic event?

A detailed analysis of the patient's inner-psychic life led to certain definite conclusions. The patient had a sharp, unconscious "oedipal conflict," originating in traumatic events in childhood. During her teen years and early adulthood, she was largely aloof to men, although she was very attractive and much sought after. The essense of this conflict is that the girl has unconscious-sexual longings for the father-figure, but these must be rigidly repressed because of the fear of the mother's retaliation (female-castration anxiety) and because to succeed in this longing would arouse a great guilt toward the mother.

In her teens she avoided the conflict by rejecting men altogether and substituted there-

for close-infantile attachment to her mother (hence the asthma in these years). As she got older, the "oedipal" strivings became more intense. The "asthma" relationship no longer could keep the conflict in balance. In her marriage choice she actually settled on a man who was a dangerously vivid replica of the father-image. She "fooled" her unconscious at first—having one child is not very much in the way of womanly fulfillment, but when she became pregnant a second time her unconscious oepidal conflicts were stirred to a dangerous pitch. How to avoid the threat of psychic disintegration?

The tuberculosis "saved" her. On the one hand, she could fulfill her ambitions as a woman by having a second baby, but she avoided fear and guilt because her tuberculosis would make sure that she really didn't "have" the baby after all—she wouldn't have the joy of mothering it; indeed another woman (the unconscious mother-figure) had the baby.

COMMENT

BASED on clinical experience as to incidence, we can say that these specific conflicts make use of these specific illnesses in an attempt at solution. Moreover, there is equal evidence for other conflict-illness specificity.

Here are the advantages to this "larger" understanding of psychosomatic disease:

(1) It fulfills the general axiom in science to pursue knowledge as far as possible.

(2) It may encourage non-psychiatric physicians to re-acquaint themselves with the problem, through orientation and/or graduate courses, and thus improve treatment of psychosomatic illnesses. For example, in the first case (peptic ulcer) the physician would be less likely to offer the general meaningless advice "you've got to take it easy"; he will instead, point out to the patient that he feels so guilty about "taking it easy," that he can only do so when his ulcer is "acting up." This may help the patient a good deal more than the standard cliche—"take it easy."

(3) The greatest advantage lies in the domain of research. It is one thing to offer this concept to the profession but quite another to make it plausible and acceptable within the framework of our traditional orientation in physiology and pathology. The "poetic" language of the theory—an unconscious conflict seeks solution by a psychosomatic illness, to preserve the psychic intactness of the organism—must be supplanted ultimately by the language or physiology and biochemistry. Already, the tantalizing question—"but how is this (the psychosomatic tissue disturbance) accomplished?"—has led to initial speculation that the bio-dynamic forces which ordinarily go along certain pathways to end up in the familiar picture of anxiety state (psychic distress, accompanied by tachycardia, sweating, and disturbance of smooth muscle and sphincters) are, in the psychosomatic illness, shunted along different paths. Thus, true anxiety state is circumvented, but tissue pathology results in its place. Moreover, this strange mechanism can be clearly differentiated from conversion hysteria, wherein anxiety is also avoided, yet by a different mechanism of organ involvement—"functional" disease of the organ.

This initial speculation inevitably leads us to more distant, but larger horizons. If psychosomatic illness is disease of the part for the benefit of the whole, what is the mystery of clinical death, where the whole dies, but the part lives on (else, how could we have eye banks, bone and artery banks?). And finally, the enigma of neoplastic disease—here life force on a primitive cellular level is set in motion with such an intensity and wild exuberance that the organismal higher-plane life is extinguished. Shall we find in these psychosomatic research areas the key—to cancer?

44 South Munn Avenue

Trustees' Minutes

January 20, 1963

A regular meeting of the Board of Trustees was held on Sunday, January 20, 1963 at the Executive Offices. For the full information of the membership, detailed minutes are on file with the secretary of each component society. A summary of the significant actions follows:

AMA Medicolegal Symposium . . . Authorized Legal Counsel to attend the symposium, to be held in Florida, March 8 and 9.

Poliomyelitis Immunization . . . Encouraged component societies to exercise leadership in poliomyelitis immunization in cooperation with local boards of health and the State Department of Health in a program best suited to their needs.

GHI vs. Howell et al. . . . Approved the action of the Executive Committee authorizing Society's Legal Counsel vigorously to participate in the defense of the action brought by Group Health Insurance of New Jersey against the Commissioner of Banking and Insurance, the Attorney General, Medical-Surgical Plan of New Jersey, and MSNJ. This action challenges the constitutionality of the law which requires that nominations of trustees for a medical service corporation in New Jersey be approved by a recognized medical society having not less than 2,000 members; and that no medical corporation be permitted to transact business in any county in which fewer than 51 per cent of the eligible physicians are participating physicians.

Advance Convention Program . . . Authorized a February advance program for the 1963 convention; and recommended that the Committee on Annual Meeting study the need for future publication of such advance program, the expenses therewith, and program publicity methods.

Workmen's Compensation . . . Approved in the following form recommendations submitted by the Special Committee on Workmen's Compensation for referral to the New Jersey Legislative Commission presently studying possible revision to the Workmen's Compensation Act:

1. Injured employees should have the right to accept the services of fully licensed physicians and surgeons of New Jersey as provided by employers, or to select another fully licensed physician and surgeon of New Jersey who is willing and qualified to perform the essential services.

2. In the exercise of his choice of another fully licensed physician and surgeon of New Jersey, the patient shall be required to inform his employer of the name of such physician, but should the patient desire to change to a second physician in the course of his treatment permission must be obtained from his employer.

3. In order to assist the Deputy Commissioner in making his determination of the degree of disability in those cases in which there is marked discrepancy in the estimates of impairment, there shall be available to him qualified specialists in the particular field of medicine involved.

4. Medical testimony and statements with regard to the injured workman should be limited to an estimate of physical impairment. In explanation, the following is quoted from the official position of the American Medical Association (adopted December, 1955), as contained in its report "Medical Relations in Workmen's Compensation":

Role of the Individual Physician . . .

The best interests of the disabled patient will be served in the following ways:

(d) Determination should be made by scientific methods and upon the basis of objective measurable factors of the permanent anatomic or functional impairment of a specified member or of his patient as a whole as compared to normal. From the medical standpoint, permanent anatomic or functional impairments cannot vary because of geographic locations or circumstances under which they were incurred. Therefore, the physician should determine the percentage of permanent impairment without regard to age, sex, occupation or real, presumed or potential wage loss. The application of these and all other factors provided by law to the percentage of permanent impairment established by the physician is the responsibility of the administrative agency in determining the indemnity award.

Clinical Psychologists Under Civil Service . . . Requested that the State Board of Medical Examiners seek a formal opinion from the Attorney General on the possible violation of the Medical Practice Act by the specifications for and duties of clinical psychologists in state institutions.

Invalidated M.D. Licenses . . . Requested that the State Board of Medical Examiners notify the appropriate component society when a license is revoked or suspended; and also when a license is restored. Licensure is a prerequisite for membership in a component and the state societies.

Blood Alcohol . . . Recorded its opinion that the present New Jersey standard of 0.15 per cent as indicative of driving while under the influence of alcohol is unrealistic; recommended that it be 0.1 per cent . . . Supplied to the Director of the Division of Motor Vehicles, in support of this opinion, the report and recommendations of the AMA Committee on Medicolegal Problems adopted by the 1962 House of Delegates.

Convulsive Seizure Legislation . . . Authorized the Special Committee on Mental Health to work with the Division of Motor Vehicles in a cooperative effort to devise a "rational and sensible" legislative enactment regarding individuals with seizure disorders.

Membership Mailings . . . Directed that E. & W. Blanksteen and American Mutual Liability Insurance Company issue all future communications to the membership on their own stationery and in their own names, and not over the signature of the Chairman of the Committee on Medical Defense and Insurance.

Pregnancy Claim under Accident and Health Insurance . . . Adopted the recommendation of the Committee on Medical Defense and Insurance that "pregnancy is a normal process and, therefore, is not an illness."

Physician-Hospital Relationships . . . Recommended that each component society and each hospital in New Jersey establish committees on physician-hospital relationships.

1963 Child Safety Week . . . Approved the recommendation of the Special Committee on Child Health that MSNJ encourage each component society to initiate local community safety councils during Child Safety Week in April 1963.

Organization of School Physicians . . . Approved the recommendation of the Special Committee on Child Health that (1) MSNJ authorize the organization of New Jersey school physicians as a project of this Committee; and (2) MSNJ and the New Jersey State Departments of Health and of Education sponsor a symposium on "The Changing Role of the School Physician" on March 27, 1963, for school physicians and administrators; and that each sponsor participate equally in the expense of the symposium, not to exceed $150 per sponsor.

Contact Lenses . . . Referred to the Council on Legislation a recommendation from the Special Committee on the Conservation of Vision that MSNJ "take steps to achieve proper legislation" to further restrict optometrists.

Hospital Consultations . . . Approved the recommendation of the Special Committee on Maternal and Infant Welfare that all New Jersey hospitals be urged to include in their bylaws the provision that "for all consultations that are required by hospital or departmental regulations, the consultant should not be associated economically with the physician who requests the consultation."

Master Plan for Mental Health . . . Approved the recommendation of the Special Committee on Mental Health that MSNJ call a one-day conference at the Executive Offices of chairmen of mental health committees of component societies, for the purpose of evaluating the mental health services and mental health needs of their local areas.

JOURNAL Advertising Rates . . . Adopted the following recommendations—effective June 1, 1963, unless otherwise stipulated—of the Publication Committee that:

a) the special local advertising rates for Convention and Transactions Issues be discontinued after this year;

b) a 65 per cent increase in advertising rates, "across the board" be effected, to bring MSNJ advertising rates in line with journals of comparable quality and size;

c) classified advertising rates—in line with this increase—be as follows: $5 for 25 words or less; 10 cents for each additional word, with payment in advance;

d) the 15 per cent "professional discount" be discontinued on advertising, except for those con-

tracts entered into by agreement with SMJAB;

c) all advertising under $50 be paid in advance.

Tobacco Advertising . . . Adopted the recommendation of the Publication Committee that—effective June 1, 1963—tobacco (cigarette) advertising no longer be carried in THE JOURNAL, in accord with AMA policy.

County Society Reports . . . Adopted the recommendation of the Publication Committee that, effective January 1963, "County Society Reports" no longer be carried as a regular feature in THE JOURNAL, in view of their duplication at county level and of the fact that not all counties submit reports.

THE JOURNAL . . . Adopted the following recommendations of the Publication Committee affecting THE JOURNAL:

a) that all advertising contracts—at local and national levels—be reviewed by Legal Counsel;

b) that several agents in the Trenton area be approached concerning possible working terms with MSNJ;

c) that certain advertising accounts for firms no longer in existence be written off as bad debts.

Making Cigarettes Harder to Get

The New Jersey Public Health Association has adopted a resolution calling for vigorous enforcement of the statute (2A:170-51) which makes it a violation to "directly or indirectly furnish a minor under the age of 16 with cigarettes, cigarette paper or tobacco in any form." The resolution also called for a substantial increase in the tax on cigarettes to make them harder to get. The Association pointed out that "no method of treating tobacco or filtering the smoke will materially reduce or eliminate the hazard of lung cancer." The resolution reaffirmed the observation of the U. S. Public Health Service that:

1. The nonsmoker has a lower incidence of lung cancer than the smoker in all controlled studies, whether analyzed in terms of rural areas, urban regions or occupations.
2. Persons who have never smoked at all (cigarettes, cigars, or pipe) have the best chance of escaping lung cancer.
3. Cigarette smoking particularly is associated with an increased chance of developing lung cancer.
4. Stopping cigarette smoking even after long exposure is beneficial.

Physicians and Cigarette Smoking*

The physician has an obligation to accept—or to re-examine—the relationship between cigarette smoking and health and to advise his patients accordingly. To be sure, cigarette smoking has declined among physicians; but doctors seem reluctant to advise patients to do what they have done themselves—cut down or quit smoking.

The individual smoker does not relate the hazard of smoking to himself either because he does not understand the extent of risk or because the day of reckoning seems remote. But here is one simple truth: evidence connecting cigarette smoking and lung cancer is more precise than some which has been accepted by physicians as a basis for action in other health problems. *Cigarette smoke contains carcinogens;* statistics confirm that what might be predicted does occur.

There are now about 40,000 deaths from lung cancer per year in the United States. Seventy-five to 90 per cent may be attributed to smoking. This is more deaths than occurred from combat among United States forces in three years of war in Korea.

Higher death rates for smokers than for nonsmokers have been reported also for cancers of the oral cavity, larynx, esophagus, and urinary bladder; for peptic ulcer, bronchiectasis and chronic bronchitis; and for certain forms of vascular disease.

The net excess of deaths from coronary artery disease in heavy smokers over nonsmokers is four times as large as the number of excess deaths from lung cancer.

*Abstracted from a paper by H. C. Taylor, M.D., Sept. 1, 1962, Journal of the American Medical Association.

Letters to The Journal • • •

Dr. George Huthsteiner, a California psychiatrist, saw our September editorial, *The Dismal Utopias of Science Fiction,* and sent the following comment.

Dear Sir:

The last sentence of your editorial—"with their loss came, apparently, a loss of hope in the perfectability of man and the feeling that the world of the future will be a dismal one,"—raises the question in my mind of how you feel about the future. Do you feel that the future of man will be worse than the present, the same or possibly better?

Is the possibility of the improvement or progress both from natural selection, human choice and creativity being considered here? Although man may never be perfect, might he not continue to improve?

"Modern psychiatry casts grave doubts on the power of reason and logic to overcome the compelling drives of biologically rooted instincts." This sentence assumes that reason and logic are the only factors involved. Secondly, that they are in opposition or conflict with instincts. Thirdly, that instincts necessarily would lead man to a dismal future. Does the honey bee and porpoise have a dismal future? Perhaps so.

The more we are burdened by the fears and phobias connected with the "Judgment Day" concept, even if consciously denied, the more pessimistic we will be about the future. The more the concepts of infinite evolution of limitless matter, energy, and space during the endless time of the future became meaningful to us and the more we recognize progress within ourselves and others as well as in man's technology, the more hope we have for the future.

In conclusion, now we need not merely *dream* of Plato's "Republic," but can *work* toward progress. Althouh we do not expect to visualize Thomas Moore's "Utopia," perhaps this communication can bring about some *improvement.*

GEORGE HUTHSTEINER, M.D.
Van Nuys, California

Dear Sir:

Your lead editorial in the current issue supporting the stand taken by our President for more substance and less image in our profession is well taken. To achieve a unified face for presentation to the public requires a reasonably unified profession.

They who would point out those shortcomings which prevent unification must take off their kid gloves when suggesting methods for the resolution of the shortcomings. My own experience in trying to get an audience for some constructive iconoclasm has been most disappointing.

So long as there are some who can turn their backs on unrest, sweep the dirt under the carpet, or fail to become indignant over injustices wreaked upon others; so long will the profession continue to stagnate in a stifling bog of its own manufacture.

Only by giving a hearing to those who demonstrate keen appreciation of the psychosocial aspects of intraprofessional matters and by the restoration of true individual worth as the yardstick for measuring the practitioner can medicine ever achieve even a semblance of unity and a sound, trustworthy public image.

PAUL B. FARRARY, M.D.

Tetanus Immunization

Are your patients properly immunized against tetanus?

The Committee on Occupational Health of The Medical Society of New Jersey once again calls attention to the need for tetanus immunization. In some cases, physicians are forced to use tetanus anti-toxin which (in spite of negative sensitivity tests) still causes alarming reactions.

The Committee on Occupational Health urges all physicians to emphasize a program for tetanus immunization both in their private practice and in occupational health programs.

Here's a good start: Tetanus immunization and boosters for every physician and his staff.

Announcements • • •

New FACP's from New Jersey

The American College of Physicians announces that the following New Jersey doctors have been installed as Fellows of the American College of Physicians: Dr. Milton Ackerman of Atlantic City; Dr. Thomas M. Kain, Jr., of Camden; Dr. Thomas C. DeCecio of Cliffside Park; Dr. Richard H. Bruning of Millburn; Dr. Richard E. Beck of Millville; Dr. Willard Nicholl of Morris Plains; Dr. DeWitt H. Smith of Princeton; Dr. Herbert W. Diefendorf of Summit; Dr. Stuart W. Cosgriff of Tenafly; Dr. Arthur Krosnick of Trenton; and Dr. Pasquale A. Ruggieri, of Vineland.

Elected as Associates were: Dr. Randall S. Nadan, Jr. of Camden; Dr. J. Colin Campbell of East Orange; Dr. J. Lawrence Werther of Englewood; Dr. Edward F. Mazur of Haddonfield; Drs. John J. Calabro, Duncan E. Hutcheon, James R. Johnson, and Bernard J. Koven, all of Jersey City; Dr. Bernard L. Rosenberg of Linden; Dr. Milton Singer of Livingston; Dr. Martin H. Wortzel of Miliburn; Dr. Roger P. Lochhead of Montclair; Dr. Herbert E. Keller of Paramus; Dr. Richard H. DuPree of Paulsboro; Dr. William F. Haynes, Jr. of Princeton; Dr. Warren B. Nestler of Summit; Dr. Peter H. Shershin of Upper Saddle River; and Dr. Victor A. Bressler of Ventnor.

Ophthalmology Courses

In New York City a series of graduate courses for specialists in ophthalmology will be given from September 3 to November 9, 1963. The curriculum will include prostheses; anomalies of extraocular muscles; ptosis; indirect ophthalmoscopy; biomicroscopy; bacteriology; tear formation; complications of surgery; contact lenses; physiology of the eye; glaucoma; gonioscopy; keratoplasties; lacrimal sac surgery; light coagulation; low vision aids; ocular biochemistry; ocular geriatrics; neuro-ophthalmology; therapeutics; orthoptics; pediatric ophthalmology; plastic eye surgery; pleoptics; psychosomatic factors in ophthalmology; cataract surgery; retinal detachment; surgery of the orbit; tonography; tonometry; and uveitis.

For Catalogue and additional information, write to Registrar, Institute of Ophthalmology; Eye and Ear Infirmary, 218 Second Avenue, New York 3, N. Y.

Medical Seminar in Philadelphia

April 23 through 26 is the time for the 27th Graduate Institute of the Philadelphia County Medical Society. A practical program has been developed, including social and economic problems of medical practice, endocrinology, drug therapy, modern pediatrics, emotional depression, surgical procedures for the GP, and gastro-enterology. For details, write to Director, County Medical Society, 301 South 21 Street, Philadelphia 3, Penna.

Smoking Education Manual Available

The State Departments of Education and Health and New Jersey Division of the American Cancer Society now help provide school and college students with facts about smoking and health. Following conferences with teachers, a manual was prepared to provide information on smoking and health.

Students or parents may ask physicians for their opinion of what the students have been told in school about the health hazards of cigarette smoking. What physicians say will reinforce or weaken the efforts of the teachers.

For further information, write Commissioner of Health, Box 1540, Trenton 25, N. J.

A Todos los Medicos de Hable Hispanica

Una esplendida opportunidad se presents ahora de poder combinar un programa de educacion cientifica con vacaciones de invierno en le hermosa y soleada America Central. Desede el 1 de Diciembre 1963 haste el 8 del mismomes, des congresos se realizaran en El Salvador, uno en Clinica Medica y el otro en Anatomia Patologica.

Gran parte de los mas importantes medicos de habla hispanica del mundo participaran de estas secioners, que incluyen entre otros actos visitas al hospital escuela.

Para mayoeres detalles, escriber al: Collegio Medico de El Salvador, 25 Calle Poniente 10-25 El Salvador, San Salvador, America Central.

Obituaries • • •

DR. MARY CARR

At the age of 82, death came to Dr. Mary Carr, one of Hudson County's senior practitioners. A 1906 graduate of New York's Eclectic Medical College, Dr. Carr was a general practitioner with special interest in obstetrics and gynecology. She was, for many decades, active in the affairs of the Hudson County Medical Society and two years ago was a golden merit laureate of The Medical Society of New Jersey. In private life, Dr. Carr was Mrs. Samuel Zullo.

DR. E. HUGH DOGGETT

One of New Jersey's veteran orthopedic surgeons, Dr. E. Hugh Doggett, died in Florida on January 25, 1963. A 1927 graduate of the medical school of the University of Tennessee, Dr. Doggett came to the Muhlenberg Hospital in Plainfield as an orthopedic resident in 1930. He liked our state sufficiently to settle here for the rest of his life. He was a charter member of, and a one-time president of, The Medical Association of Plainfield. Dr. Doggett served for some years as senior attending orthopedist at the Muhlenberg Hospital and was, for several terms, an officer of that hospital's medical board. Born in 1891, he retired in the spring of 1960 and moved to Florida at that time.

DR. ABEL GORDON

Dr. Abel Gordon, one of Passaic's senior ophthalmologists, died on January 15, 1963. Born in New York in 1903, he earned his M.D. in 1926 at the medical school of the University of Maryland. After concluding his internship, he went to Austria and Hungary in the late 1920s for graduate work in ophthalmology and otolaryngology. He returned to Passaic thereafter and limited his practice to ophthalmology. Dr. Gordon was one of the first in New Jersey to be certified in ophthalmology. That was in 1933 when certification was relatively unusual. During World War II, he served in the medical corps, and for some years thereafter was a consulting ophthalmologist to the Regional Office of the Veterans Administration. Dr. Gordon was affiliated with the New York Eye and Ear Infirmary.

DR. AUGUST M. JONAS

One of Salem County's pioneer physicians died on January 26, 1963, with the passing of 74-year old Dr. August Jonas. Born in Alsace-Lorraine, he won his M.D. at the University of Strassburg in 1913. A successful practitioner in his native land, he decided to move out soon after Hitler came to power, and he came to the United States in 1934. He took and passed the New Jersey State Board Examinations (though by then he had been out of medical school 21 years) and opened an office, first in Bridgeton, then in Salem. He served the Salem Memorial Hospital and was a popular family physician and general practitioner throughout much of South Jersey.

DR. GEORGE L. NICOLL

Born in India (where his parents were missionaries) Dr. George L. Nicoll entered Rush Medical College in Chicago in 1927 and received his M.D. degree there in 1931. During World War II he was a Commander in the Navy. He was a general surgeon in Dover and had a tour of duty as president of the Morris County Medical Society. He was an FICS and had several terms as president of the staff of the Dover General Hospital. The Deputy County Physician, Dr. Nicoll was also an attending surgeon at St. Clare's Hospital in Dover. Dr. Nicoll died on January 12, 1963, after a long illness. He was 59 years old at the time of his death.

DR. JEREMIAH O'BRIAN

After a long illness, Dr. Jeremiah O'Brian, one of the pioneer urologists in the Passaic-Bergen area, died on January 17, 1963. Born in upstate New York in 1897, he received his M.D. at the University of Vermont in 1922. Dr. O'Brian was director of urology at the Passaic General Hospital. Dr. O'Brian was active in committee work with the Passaic County Medical Society, of which he had been a member for more than 40 years.

DR. GEORGE M. RELYEA

A long illness finally took the life of Dr. George MacDougal Relyea, who died on February 1, 1963. Born in Canada in 1901, he received his M.D. in 1929 at the University of Michigan. After interning, he joined the Summit Medical Group. In 1941 he was commissioned in the Army Medical Corps, and after five years of active military duty, he returned to civilian life and accepted an appointment with Ciba Pharmaceuticals. Dr. Relyea served the company thereafter and was well known in industrial medical circles. He was active in committee work for the Union County Medical Society.

Book Reviews • • •

General Pathology. Edited by Sir Howard Florey. Philadelphia, 1962, Saunders. Third Edition. Pp. 1104, illus. ($22.00)

This third edition of Florey's lectures on general pathology is a true dessert for anyone who has previously tried to ingest a repast of the subject of pathology. The associate authors have contributed much to the volume, and as Professor Florey states in the first edition, the volume is primarily for those who have enrolled in the Honor School of Physiology at Oxford. The author's initial lectures on the history of pathology are a delight.

The volume is unique in that the inflammatory reaction and its cellular minutiae are exceptionally well illustrated by photomicrographs made with the electron microscope. These illustrations are a distinct contribution to the study of inflammation and a definite attempt to widen the frontiers of scientific information for the average reader is noted.

In the discussion on anemia and the sedimentation rate, the reviewer was sympathetic to the author's statement that attempts to control complicating factors by the use of correction charts have introduced insoluble problems and none is satisfactory.

Chapter 6 in the volume, dealing with the secretion of mucus and inflammation of mucous membranes, had more of a physiologic than a pathologic quality. A similar tone was noted in the discussion of hemorrhage and shock, fever and edema.

The chapter on immunologic tolerance gives the volume a more advanced aspect, and the author is to be complimented on his ability to present basic scientific concepts from the realm of contemporary experimentation. The concept that connective tissue is the biologic moderator of cellular energy put forth by the associate author, Robb-Smith, was impressive.

The reviewer was greatly impressed with the basic detail concerning scientific experimental methods and correlated facts which are contained in the volume. It is the reviewer's opinion that what other authors have hinted about scientific methodology, Florey has related in a factual manner.

The volume will be long remembered by those who appreciate scientific inquiry in the fields of general pathology. It can be recommended to all graduate medical students and those interested in master's or doctor's degrees in the basic sciences.

THOMAS K. RATHMELL, M.D.

Classics in Cardiology. Frederick A. Willius, M.D. and Thomas E. Keys, M.A. New York, 1961. Dover Publications, Inc. Pp. 858, illustrated, 2 vols. ($2.00 each)

Cardiac Classics was first issued in 1941. It was edited by Dr. Frederick A. Willius, cardiologist, and Mr. Thomas E. Keyes, librarian to the Mayo Clinic. Now it appears in paperback form under the title *Classics of Cardiology.* It covers two sturdy, portable volumes. Its subtitle announces the scope and content of the work: "A Collection of Classic Works on the Heart and Circulation with Comprehensive Biographic Accounts of the Authors."

The record chronicled by these volumes is comprehensive and impressive. Beginning with William Harvey's *Anatomical Disquisition on the Motion of the Heart and Blood in Animals* (1628), the development of cardiology is brought up to James B. Herrick's classic report, *Clinical Features of Sudden Obstruction of the Coronary Arteries* (1912). In its survey of cardiovascular milestones from the seventeenth to the twentieth century, the collection includes contributions by Malpighi, Morgagni, Auenbrugger, Heberden, Withering, John Hunter, Corvisart, Laennec, Adams, Stokes, Austin Flint, Graham Steell, Fallot, Einthoven, Aschoff, Mackenzie, Osler, and others. Fine biographic material, over one hundred illustrations, two indices, and a detailed bibliography also contribute to the attractiveness of these volumes. The reissuing of this in paperbook form is a notable occasion.

FRED B. ROGERS, M.D.

Errant Ways of Human Society. By Julius Bauer, M.D. New York, 1961. Vantage Press. Pp. 162. ($3.00)

Born in Europe in 1887, Dr. Bauer came to this country in the 1930s. Apparently he doesn't like us. In this book, he lectures on the many faults he finds in the United States. American colleges, he says, "spend time to achieve an educational level that has always been achieved in European secondary schools *before* admission to the University." He doesn't like American methods of teaching school children to read. ("This method," he writes, "was tried in the schools of Vienna under a socialist government.") He says that "to be a regular guy

is at a premium in the U.S.A. and strict conformism is a prerequisite." He disapproves of John Dewey. In America, he thinks, the child is allowed to do as he pleases, and is not even scolded. As for medical research in our country, that is dismissed thus: "Ideas are not held in high esteem in our mechanically oriented medicine." America, he finds, "wastes large amounts of money for projects proposed by sociologists, concerned with paramedical problems."

Jury trials he considers an "anachronistic relic." (Apparently he liked justice better in Europe.) And hear this: "American medicine as part of American culture is very young and lacks sense of tradition." America's whole "educational system needs fundamental changes to compete with that of European countries." He might also have added that we have a strange trait of masochism, too.

HENRY A. DAVIDSON, M.D.

Mental Health in the Metropolis. Leo Srole, Ph.D. and others. New York, 1962. McGraw-Hill. Pp. 428. ($9.95)

Last spring, newspapers carried stories to the effect that four out of five had mental illness. These were dramatized and distorted impressions that came out of the psychiatric survey of midtown Manhattan by the Cornell group. The study, itself, as reported in this book, is somewhat less spectacular and more valid than those headlines suggested. The "four out of five" figure was, of course, utterly misleading. The surveyors found that out of every five residents of the subject district, only one had a marked or incapacitating emotional disorder, three "carried varied loads of tension-denoting symptoms," and one was in fine mental health.

I doubt if the area studied is representative of the United States, or even of urban locations. The large number of working wives and the small number of children rather badly skew the picture. The proportion of females was well over the national average. The curious mixture of paupers and millionaires also contaminated the profile.

The surveyors found that groups with the largest ratios of disturbed people had the fewest people under treatment and *vice versa*, suggesting that treatment-mindedness and economic resources were major (and statistically-distorting) factors.

While the text is somewhat pedestrian in style (and the footnotes frightening), the book on the whole is solid in content and thought-provoking in effect. It has to be taken slowly, thoughtfully, and in small doses. But to anyone interested in the epidemiology of emotional illness, this is a gold mine.

ABRAHAM LEFF, M.D.

Progesterone and the Defense Mechanism of Pregnancy. Edited by G.E.W. Wolstenholme, M.D. and Margaret P. Cameron. Boston, 1961, Little, Brown and Company. Pp. 108, with 22 illustrations. ($2.50)

This highly technical volume is concerned with experimental data on laboratory animals. It reports on the role of progesterone in blocking labor, the interaction of placenta and ovaries and the questionable role of the fetus in progesterone production, and finally the physiology of the uterine muscle cell itself, and differences in placental and non-placental sites. Included are papers on (1) Defense mechanism of pregnancy; (2) Relationship between progesterone production in the human placenta and the fetus; (3) Molecular aspects of the contractile mechanism of the uterus, and its changes during pregnancy; (4) studies in electrophysiology of the uterus; (5) A commentary by a practicing obstetrician, and (6) Round table discussion.

The obstetrician, like most clinicians, showed impatience with the researcher. He questioned some of the laboratory conclusions in the light of clinical experience. However, during the round table discussion, all were agreed that the pregnant uterus has not yet given up all its secrets.

This volume is of especial interest to those familiar with the procedures in basic experimental physiology. It gives obstetricians a glimpse into the highly specialized and skillful groundwork which precedes a new discovery that can ultimately be used for the patient's benefit.

ZELDA I. MARKS, M.D.

Pharmacology and Therapeutics. By Arthur Grollman, M.D. Philadelphia, 1962. Lea and Febiger. Fifth edition. Pp. 1131. ($12.50)

Within ten years this book has had five editions—ac olade enough. The text follows the conventional pattern of starting with a discussion of drug properties, dosages and fate of drugs in general. Then comes an analysis of specific therapeutic agents, grouped by focus of action—drugs acting on the nervous system, on the cardiovascular system and so on, followed by a chapter of chemotherapeutic agents, material on hormones and vitamins, a surprisingly long chapter on metallic and inorganic compounds (including rubidium which, it says, acts like potassium on frog's heart) and a short monograph on the technic of prescription writing. Very handy is an eight-page appendix which classifies drugs according to therapeutic use in ready-reference form. While somewhat pedestrian in style, the book does bridge the gap between the overly compressed manual and the encyclopedic reference work.

ULYSSES M. FRANK, M.D.

The Abortionist. As told to Lucy Freeman by Dr. X. Garden City, N. Y., 1962. Doubleday. Pp. 216. ($3.95)

Most of us are familiar with the dilemma dramatized by the title of this book's first chapter: "When Mercy is Crime." What we have here is a triple-barreled story: an interesting account of how a good physician became an abortionist with a behind-the-scenes view of the abortion business; second, a realistic story of his four years in prison where every effort seems to have been made to degrade him; then a record of his rehabilitation through psychiatry. One result of this psychotherapy was that he was able to return to doing abortions. The psychotherapy was successful though; he no longer felt anxiety or guilt about it. The text includes many interesting and well-told stories about girls in trouble; and concludes with a plea for more liberal and less hypocritical abortion laws.

VICTOR HUBERMAN, M.D.

The Doctors' Dilemmas. By Louis Lasagna, M.D. New York, 1962, Harpers. Pp. 306. ($4.95)

In a curious melange of topics, Lasagna talks about medical history, the AMA, quacks, the drug industry, forensic medicine, vitamins, Congressional investigations, voluntary health agencies, religion and the training of physicians. The author, a Johns Hopkins pharmacology professor, has strong views which he expresses with startling, but never disarming, frankness. Among the things he does not like are krebiozen, the current AMA leaders, folk medicine, vegetarianism, the National Tuberculosis Association and the overselling of vitamins. He is dogmatic in his own views, breezily dismissing other doctrines.

He takes the drug industry to task for its merchandising methods. He writes: "Are the physicians of America really so gullible as to be taken in by phoney advertising? The answer is Yes." His attitude towards the AMA is reflected by these passages: "In its basic approach the AMA acts to safeguard what it considers the best interests of the profession. This fundamental fact is not owned up to publicly, where the pitch is that AMA is primarily concerned with the welfare of the American people. There is probably an element of self-delusion in the pious pronouncements of AMA officials." AMA's activities in connection with the Kefauver hearings are described this way: ". . . the performance reinforced the conviction that AMA policy is more often than not of the 'public be damned' variety when free enterprise and the profit system are involved."

Dr. Lasagna is never subtle. Thus, "A depressing aspect of AMA activities is the apparent decline in the quality of its leaders . . . For the last 15 years, AMA presidents have, for the most part, not been distinguished by their scientific fame or contributions to medical progress. The best minds in medicine eschew the area of medical politics. The years marked by the AMA's decline in public appeal have been those marked also by the choice of AMA leaders who were less than the very best the profession had to offer."

This book is not recommended reading for patients, since it is bound to fan some flames that ought to be given a chance to cool. It is a thoughtful, provocative and slickly written book. While you may not always agree with the author, you always know where he stands. Which, these days, is no mean virtue.

HERBERT BOEHM, M.D.

Carcinoma of the Cervix. By John B. Graham, M.D., Luciano S. J. Sotto, M.D. and Frank P. Paloucek, M.D. Philadelphia, 1962. Saunders. Pp. 487, illustrated. ($14.00)

There is probably no subject in obstetrics and gynecology which arouses more discussion, difference of opinion and confusion, than carcinoma of the cervix. Out of the maze of available information Graham and his co-authors have constructed a comprehensive and well-organized discussion of all phases of this all-too-common cancer.

The book opens with an exhaustive and surprisingly readable statistical analysis of the prevalence and possible etiologic factors and it closes with a similar evaluation of our results. In between, the pages contain well presented, carefully sifted material regarding all aspects involved in effecting prevention and cure. Pathology and *carcinoma in situ* are concisely discussed. Diagnostic technics from bimanual examination to colpomicroscopy, are covered in detail. The section on "staging" of disease and prognosis is outstanding, including a brief but clear presentation of R.R. and S.R. prognostic evaluations direct from the original source. The chapters on elementary radiation, physics and radiotherapeutic concepts and technics are explicit and lucid.

The introductory statement, "We are fortunate that there are two effective methods of treating cancer of the cervix," crystallizes the authors' attitude towards the current controversy over mode of therapy. Surgery and radiation are extensively discussed with all their advantages, disadvantages and complications. Selective, important comparative statistics are used to advantage. This whole work presents a readable and informative guided tour through the many facets and byways of the problem, with extensive bibliographies and thumbnail case histories adding value and interest.

J. B. SKELTON, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

MARCH 1963 • VOL. XXXVI, NO. 3

ROLE OF TOBACCO SMOKING IN CAUSATION OF CHRONIC RESPIRATORY DISEASE

Study undertaken in population group in Berlin, New Hampshire, revealed significant link between cigarette smoking and chronic respiratory diseases. Risk of disease doubled after 3000 packs of cigarettes had been smoked, the equivalent of one pack a day for eight years.

In a study of chronic respiratory disease undertaken in Berlin, New Hampshire, in 1961, the prevalence of various forms of respiratory disease according to age, sex, current tobacco smoking habits, and lifetime cigarette consumption was determined. A questionnaire supplemented simple tests of pulmonary ventilation in a probability sample of residents 25 to 74 years of age.

Subjects were assigned to one of the following categories: never smoked cigarettes; former smoker of cigarettes; and currently smoking 1 to 10, 11 to 20, 21 to 30, 31 to 40, or 41 or more cigarettes a day.

The approximate number of packages of cigarettes smoked during a lifetime was estimated from the age the subject began regular cigarette smoking.

DISEASE CLASSIFICATIONS

The disease categories were defined as *chronic bronchitis,* if a subject produced phlegm on at least four days a week for three months of a year for three years; *asthma,* if a subject had a history of bronchial asthma and it was still present (because asthma was usually associated with one of the other diseases, it was not analyzed separately); *irreversible obstructive lung disease,* if a subject had a history of wheezing or whistling in the chest and dyspnea not due to known causes; and *all chronic respiratory disease,* including all subjects who had at least one of the diseases listed above.

There was a regular increase in the prevalence of chronic bronchitis with age in men, ranging from 24.1 per cent in the age group 25-34, to 34.7 per cent in those 65-74. The age gradient in irreversible obstructive lung disease was irregular for both men and women.

The prevalence of chronic respiratory disease in men consistently exceeded that in women for each age group except that from 25 to 44; women in this age group had a slightly higher prevalence of irreversible obstructive lung disease. Irreversible obstructive lung disease appears to be more frequently combined with chronic bronchitis in men than in women. In women the latter may remain a pure disease, with little sputum.

Of the 532 men interviewed, 261, or 49.1 per cent, were currently smoking cigarettes, and 200, or 32.9 per cent, of 607 women were cigarette smokers.

INCREASED SMOKING—RISE IN RD

There was almost uniform progression in the prevalence of all chronic respiratory disease, chronic bronchitis, and irreversible ob-

DONALD O. ANDERSON, M.D.; BENJAMIN G. FERRIS, JR., M.D.; *New England Journal of Medicine,* October 18, 1962.

structive lung disease with increasing cigarette smoking. Among men, the rate for all chronic respiratory disease rose from 19.7 per cent among those who had never smoked cigarettes to 87.7 per cent among those who smoked more than two packs a day. Among women, it rose from 17.2 per cent among nonsmokers to an average of 43.3 per cent among all those who smoked more than a pack a day.

The comparable rates for chronic bronchitis in relation to the number of cigarettes smoked were, for men, from 15 per cent among nonsmokers to 75.3 per cent among those who smoked more than two packs a day, and, for women, from 9.4 per cent (nonsmokers and exsmokers) to an average of 27.3 per cent of those who smoked more than a pack a day.

Chronic respiratory disease in smokers increased above that of nonsmokers only when a threshold of 3,000 packages had been passed, or the equivalent of one package a day for about eight years.

Despite age standardization, the risk of disease doubled after 3,000 packs had been smoked, and more than tripled after 18,000 packs. However, after standardization to lifetime cigarette exposure, age was found to be no longer significantly associated with the presence of any disease in men; a *significant* association with age remained for irreversible obstructive lung disease in women.

LIFETIME SMOKING SIGNIFIED

Since the lifetime cigarette-smoking exposure was a function of age, current and past smoking habits and the age smoking began, it could logically be regarded as a composite of several variables. In men, however, after standardization to lifetime exposure, current cigarette smoking was still found to be *significantly* associated with the presence of chronic bronchitis but no longer with the presence of irreversible obstructive lung disease. After standardization to current cigarette-smoking habits, however, lifetime cigarette-smoking exposure was still found to be *significantly* associated with the presence of chronic bronchitis and *highly significantly* associated with the presence of irreversible obstructive lung disease. In women, however, standardization to either variable completely removed any significant association of the other variable to all forms of chronic respiratory disease.

RELATIVE RISKS

The greater relative risk of sickness and death from chronic respiratory disease in smokers as compared to nonsmokers has been reported in case-history studies of patients with chronic bronchitis and emphysema and by cohort studies.

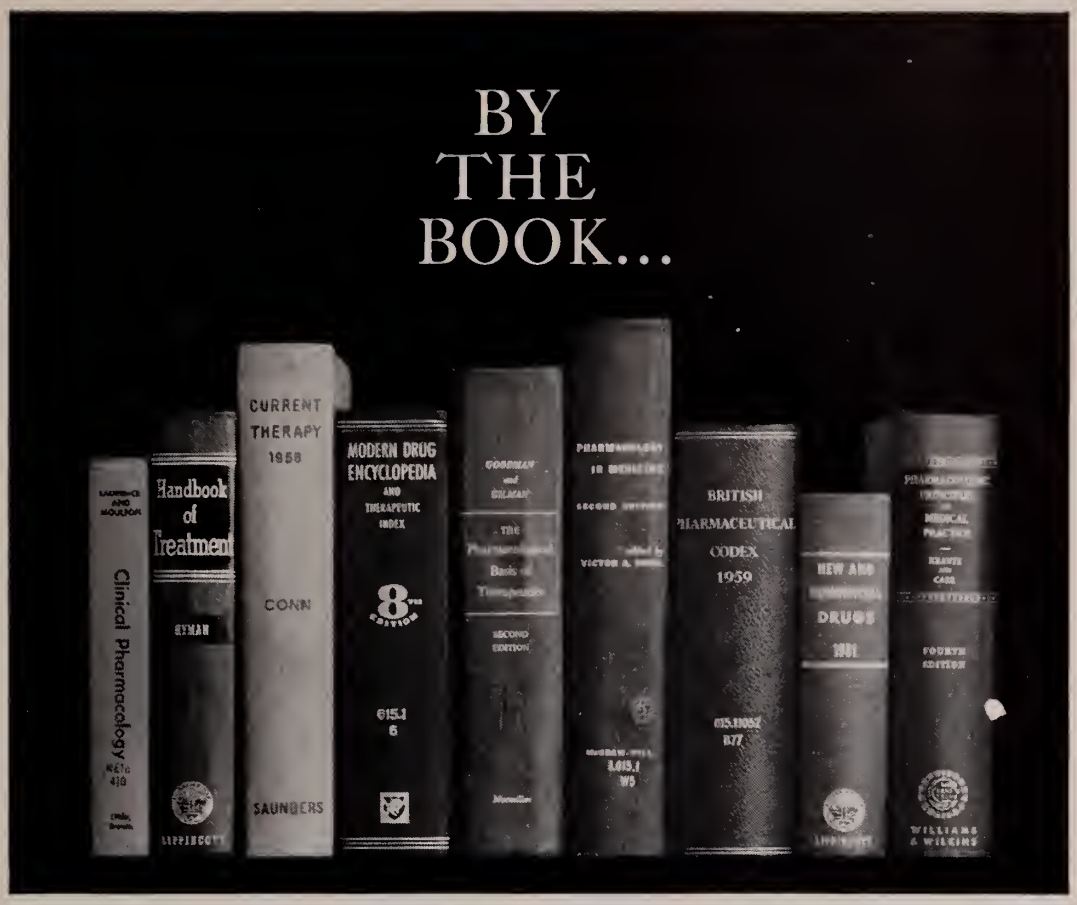
In the present report the increased rates of disease have been expressed as relative risks on the basis of the rate in those who had never smoked as unity.

Pipe and cigar smokers were found to have a greater risk of disease than subjects who had never smoked tobacco. However, those who smoked cigarettes and a pipe or cigars did not have any increased risk of disease above that observed in cigarette smokers alone.

Certain evidence from this study supports the hypothesis that there may be a threshold beyond which cigarette smoking materially increases prevalence of chronic respiratory disease. The data indicate that it lies above 3,000 and below 9,000 packages or after eight years of cigarette smoking at the rate of between one and three packages a day. The precise threshold is not clear, and further studies are indicated.

The observation that cigarette smoking is clearly associated with the prevalence of chronic respiratory disease means that any demographic or epidemiologic study must standardize for its effect in some acceptable epidemiologic fashion. Nonsmokers may be the most suitable subjects in whom the effects of atmospheric pollution or occupational exposure to noxious dusts or gases should be studied.

New Jersey Tuberculosis and Health Association
15 East Kinney Street, Newark 2, New Jersey



PRO-BANTHĪNE®

brand of propantheline bromide

in
- peptic ulcer
- gastritis
- biliary dyskinesia
- spastic colon
- pylorospasm
- functional gastrointestinal disorders

Prompt, positive control of excess gastrointestinal acidity and motility has earned for PRO-BANTHĪNE the widest acceptance as the standard anticholinergic medication.

Authorities in pharmacology and therapeutics recognize the beneficial actions of PRO-BANTHĪNE. Clinicians prescribe it more often than any other drug of its class.

In patients with peptic ulcer or other conditions characterized by hyperfunction of the enteric tract, PRO-BANTHĪNE relieves pain, suppresses excessive secretion and motility, prolongs the neutralizing property of antacids and hastens resolution of the disorder.

The books say "PRO-BANTHĪNE" when anticholinergic medication is indicated.

PRO-BANTHĪNE is supplied in seven forms and combinations for every clinical need.

PRO-BANTHĪNE Tablets of 15 mg.
PRO-BANTHĪNE Ampuls of 30 mg.
PRO-BANTHĪNE P.A.® (Prolonged Acting) Tablets of 30 mg.
PRO-BANTHĪNE *(Half Strength)* Tablets of 7.5 mg.
PRO-BANTHĪNE® *with* DARTAL® Tablets, containing 15 mg. of PRO-BANTHĪNE and 5 mg. of Dartal (brand of thiopropazate dihydrochloride).
PRO-BANTHĪNE *with* PHENOBARBITAL Tablets, containing 15 mg. of PRO-BANTHĪNE and 15 mg. of phenobarbital.
PROBITAL™ Tablets, containing 7.5 mg. of PRO-BANTHĪNE and 15 mg. of phenobarbital.

G. D. SEARLE & CO.
CHICAGO 80, ILLINOIS
Research in the Service of Medicine



they never even had a chance to complain about the cost of drugs

Walk through any older cemetery, and you will find the same ugly story repeated many times. Died, age 30 years... died, age 8 years... died, age 6 months.

Sometimes, you will see evidence of entire families being struck down almost simultaneously. You wonder, was it influenza? Diphtheria? Infectious diarrhea? Or a host of other diseases whose very names were synonymous with terror?
You will see, "Died, age 22—childbirth."

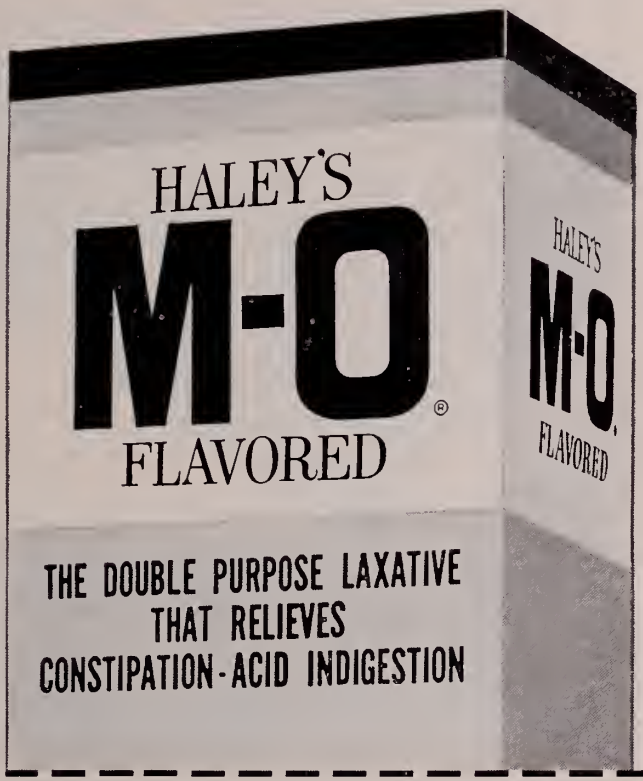
There are many reasons why you don't see a continuation of these tragic stories today—not the least of which has been the dedication of American physicians and the quality of medical education. And another, we sincerely believe, has been the quality of medicines which have been made available.

Yet, the value of independent drug research has been seriously challenged—research which has, in the past 30 years alone, helped to add nearly 10 extra years to the average lifespan in the United States. Yet, because the cost of the search must be reflected in the price the patient pays for a prescription, is it too expensive to continue? Unfortunately, perhaps those who might have the best answer can offer only silent testimony.

This message is brought to you on behalf of the producers of prescription products.

A reproduction, for display in your waiting room, is available. Write:
PHARMACEUTICAL MANUFACTURERS ASSOCIATION • 1411 K STREET, N.W. • WASHINGTON, D.C.

NOW ALSO IN FLAVORED FORM!



BOTTLES OF
4 OZ., 8 OZ.,
1 PT., 1 QT.

Antacid–Laxative–Lubricant to help correct constipation

Magnesium Hydroxide plus pure mineral oil make *Haley's M-O* a smooth working antacid-laxative-lubricant that efficaciously relieves constipation and attendant gastric hyperacidity.

The oil globules in *Haley's M-O* are minutely subdivided to assure uniform distribution and thorough mixture with intestinal contents. Oil leakage is thus avoided and a comfortable evacuation is effected through the stimulation of normal intestinal rhythm and blunted defecation reflex.

May we send samples for your evaluation? Just write:

THE CHAS. H. PHILLIPS CO.

Division of Sterling Drug Inc., 1450 Broadway, New York 18, N. Y.

Webcor Music Man

STEREOPHONIC HIGH FIDELITY TAPE RECORDER

...the ultimate in tape recorder performance!



PRICED AT only $198.80

- 2 and 4 track stereo operation
- 3 speeds—1⅞, 3¾, and 7½ ips.
- New, simplified "push-lever" operation
- Self-contained stereo record and playback
- Digital tape counter with pushbutton reset
- Dual volume controls—one for each channel
- Dual bass and treble controls

If you're the "one in a hundred" with a highly critical ear for perfection in sound, you'll be satisfied with nothing less than the new Webcor "MUSIC MAN" stereo tape recorder. And it's ever so simple to operate! Just push the lever up to "Play"... push it down to "Stop"... move it to the left to "Rewind"... to the right for "Fast Forward." Treat yourself to a thrilling new hearing experience. Ask for a demonstration today at—

Write for catalog to Exclusive N. J. Wholesale Distributors

ALL-STATE DISTRIBUTORS

INCORPORATED

457 CHANCELLOR AVE. NEWARK, N. J.

WAverly 3-4900

Trocinate®

Brand of Thiphenamil HCl.

FOR DIVERTICULITIS, MUCUS COLITIS,

IRRITATIVE DIARRHEA, IRRITATIVE URETERITIS,

BLADDER SPASM

*T*rocinate is a musculotropic antispasmodic with no appreciable anticholinergic action. It relieves spasms of the lower bowel and genito-urinary tract by direct action on the contractile mechanism of smooth muscles. The absence of any appreciable action on the autonomic nervous system eliminates the usual side-effects. It may be safely used in glaucoma. Each tablet contains 100 mgs. Trocinate HCl.

USUAL DOSAGE: 2 tablets, 4 times a day. Maintenance dosage is frequently lower.

Dispensed in bottles of 40 and 250 tablets.

WM. P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856

NEW YORK FERTILITY INSTITUTE

For the Investigation of Problems of Human Infertility

The Institute provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

Patients are accepted by the Institute only by doctor referral and returned to the referring physician after appropriate studies have been made, together with a complete detailed report of the findings of the Institute and its consultants and recommendations for therapy. Literature on request.

123 East 89th Street, N. Y. 28, N. Y.

Phone: TR 6-9300

DUGAN'S

"Bakers for the Home"

New - LITE DIET BREAD

(White Bread Baked Without Shortening)

Calories per Slice 42 Calories per oz. 70

ALSO

SALT-FREE BREAD
GLUTEN AND PROTEIN BREADS
100% WHOLE WHEAT
100% Whole Wheat Crackers

New York New Jersey
Connecticut Pennsylvania

"At Your Door or To Your Store
It's DUGAN'S for BETTER Baked Goods"

Phone for Delivery

HUmboldt 2-6007 in Newark

(or your local phone book for branch nearest you)

FAIR OAKS HOSPITAL

SUMMIT, NEW JERSEY

CRestview 7-0143

OSCAR ROZETT, M.D.
Medical Director

MOLLIE KENNEDY, R.N.
Director, Nursing Service

EDWARD R. DUTY, M.D.
Clinical Director

N. M. JANI, M.D.
S. D. ESTRADA, M.D.
Associate Psychiatrists

THOMAS P. PROUT, JR.,
Administrator

AN 85 BED INTENSIVE TREATMENT PSYCHIATRIC UNIT

Certified by
The Joint Commission on Accreditation of Hospitals
The Central Inspection Board, American Psychiatric Assn.







LONG TERM AUTO LEASING

. . . A SERVICE ESPECIALLY PLANNED FOR DOCTORS!

M.D. PLATES FREE, TOO!

AAL LONG TERM SINGLE CAR AND FLEET RENTALS

Call ORange 6-7137 or

MAIL COUPON TODAY

Lease a brand new Cadillac or other fine car from American and you'll never **buy** again. Save money, time and trouble. One modest monthly payment takes care of everything . . . insurance, maintenance, repairs, depreciation . . . and the payments are 100% tax deductible! Borrow a car—free of charge—in case of accident or breakdown.

INCLUDES

- Registration and plates
- Full maintenance
- Insurance

Liability $250/$500,000
Property damage $20,000
Deductible collision,
fire and theft

AMERICAN AUTO LEASING COMPANY
120 Halsted St., East Orange, N. J.
Please send me the AAL Long Term Leasing Plan.

Wide Selection of '63 Models

Special requirements _____

_____

Name _____

Address _____

City _____ State _____

ALL YOU BUY IS GAS AND OIL

ASK FOR BROCHURE

AAL

AMERICAN AUTO LEASING COMPANY

120 Halsted Street, East Orange, New Jersey • ORange 6-7137

Ranch Type - Luxurious

THE PARKWAY NURSING HOME, INC.



1201 PARKWAY AVE.
Trenton, N. J.
882-6900

No Steps!
New audio-visual intercom system from every patient to Nurses.

One of New Jersey's newest, most modern and completely equipped Nursing and Convalescent Homes, catering to the Convalescent, Aged, and Chronically Ill.

Referring physician has full medical privileges
Complete 24-hour general nursing care
Physical rehabilitation department
Beauty parlor — air-conditioned dining room, lounge, and lobby — spacious patios

Ultra modern interiors with artistic color scheme
Stainless steel kitchen tiled to ceiling
Special diets — planned social and recreational activities

Residential Section
Reasonable Rates

The Parkway Nursing Home

NEW JERSEY STATE LICENSED

MEMBER OF AMERICAN NURSING HOME ASSOCIATION

A NATURAL Treatment For Gastro-Intestinal Disorders

An implantation of l. acidophilus bacilli in the digestive tract will frequently restore intestinal flora to a normal, healthy condition. Walker-Gordon Acidophilus (a 2% butterfat product made from Walker-Gordon Certified Milk) abounds in lactobacilli acidophilus... 500 million per ml. Write or phone for professional sample of Acidophilus and complete information.

Guaranteed Free of Penicillin

WALKER-GORDON ACIDOPHILUS

Walker-Gordon Certified Milk Farm, Plainsboro, N.J. SWinburne 9-1234

New York: WAlker 5-7300 ☆ Phila.: PEnnypacker 5-3465

Also Producers of Certified Raw, Pasteurized, Homogenized-Vit. D, Skimmed and Fresh Lo-Sodium Milks.

Available through leading Milk Dealers or write Walker-Gordon

The Morristown Rehabilitation Center

66 MORRIS STREET **MORRISTOWN, NEW JERSEY**

JEFFERSON 9-3000



NATHAN KAPLAN, M.D., Physiatrist
MARY E. JOHNSON, Chief Therapist

ANN G. McMANUS, R.N.
Director of Nursing Service

AUDREY E. TAHLMORE
Administrator

A 38-bed rehabilitation unit specializing in orthopedic and neurological disabilities. Speech therapy, Occupational therapy and psychological evaluation available.

- - - - - -

AMERICAN HOSPITAL ASSOCIATION ACCREDITATION
MEMBER NEW JERSEY LICENSED NURSING HOME ASSOCIATION

REPRESENTATIVE FUNERAL DIRECTORS

OF THE STATE OF NEW JERSEY

Special and Dependable Service Day and Night. Special Attention Given to Hospital Calls, Train and Express Shipments.

Place	Name and Address	Telephone
ADELPHIA	C. H. T. Clayton & Son	FReehold 8-0583
BLOOMFIELD	George Van Tassel's Community Funeral Home	PIlgrim 3-1234
BOONTON	Lewis & Carey Incorporated, 312 W. Main St.	DEerfield 4-0842
CRANBURY	A. S. Cole Son & Co., Main St.	EXport 5-0770
ELIZABETH	Aug. F. Schmidt & Son, 139 Westfield Ave.	ELizabeth 2-2268
ENGLEWOOD	Greenleaf Funeral Home, Inc., 108 W. Palisade Ave.	LOwell 8-0416
FREEHOLD	Higgins Memorial Home, 20 Center St.	HOpkins 2-0895
JERSEY CITY	McLaughlin Funeral Home, 591 Jersey Ave.	OLdfield 3-2266
LINDEN	Don McCracken Funeral Home, 2124 St. Georges Ave.	ELizabeth 2-9190
METUCHEN	Runyon Mortuary, 568 Middlesex Ave.	LIberty 8-0149
NEWARK	Barrish Funeral Home, 684 Clinton Ave.	ESsex 3-1551—9179
PATERSON	Legg, R. Charles D. & Sons, 384 Broadway	SHerwood 2-2385
RAMSEY	The Harold Van Emburgh Funeral Home, Inc.	DAvis 7-0030
RIDGEWOOD	C. C. Van Emburgh, Inc., 306 E. Ridgewood Ave.	GIlbert 5-0344
RIVERDALE	George E. Richards, Newark Turnpike	TEmple 5-0164
SOUTH RIVER	Rezem Funeral Home, 190 Main St.	SOuth River 6-1191
TRENTON	Ivins & Taylor, Inc., 77 Prospect St.	EXport 4-5186

"Prescribe with Confidence"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR
FOR MEN - WOMEN - CHILDREN



SOLD ON Rx ONLY
OUTFLAIR SHOES
FOR CLUB FEET

177A JEFFERSON AVE. PASSAIC, N. J.

69 WESTWOOD AVE. WESTWOOD, N. J.

350 MAIN ST. HACKENSACK, N. J.

Dennis Brown Splints — in all sizes — carried in stock

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

Place	Name and Address	Telephone
BERGENFIELD	Horn's Pharmacy, 475 So. Washington Ave.	DUmont 4-1119
BLACKWOOD	Worrell's Pharmacy, 12 So. Black Horse Pike	CAnal 7-0430
BLOOMFIELD	Burgess Chemist, 56 Broad St.	PIlgrim 3-1005
BLOOMFIELD	Jay W. Clark, Pharmacist, 170 Broad St., Believille Ave.	PIlgrim 3-4150
CLOSTER	Mid Town Pharmacy, 237 Closter Dock Road	PO. 8-0070
DUMONT	Lenrow's Pharmacy, Inc., 10 W. Madison Ave.	DUmont 4-0842-1500
EDISON TOWNSHIP	Walter's Pharmacy, 1034 Amboy Ave.	LIberty 8-2614
EMERSON	Emerson Pharmacy, 201 Kinderkamack Road	COlfax 2-4999
FARMINGDALE	Burke Rexall Drugs, Main St. opp. Bank & Post Office	WEbster 8-9051
FREEHOLD	Wood's Pharmacy, 2 E. Main St., cor. South	FReehold 8-0668
HIGHLANDS	Highlands Pharmacy, 148 Bay Ave.	872-1550
JERSEY CITY	J. B. Feinberg Pharmacy, 659 Newark Ave.	OLdfield 3-6376
JERSEY CITY	Fred T. Fiore, 14 Rose Ave.	DElaware 3-7509
JERSEY CITY	Honiberg Drug & Surgical Supply Co., 618 Newark Ave.	SWarthmore 8-6700
JERSEY CITY	Lauria's Pharmacy, 768 West Side Ave.	HEnderson 3-1519
KEYPORT	Sav-On-Drugs, J. Meisler, opp. Post Office.	COlfax 4-0904
LAKEWOOD	Burke Rexall Drugs, Cor. 4th and Monmouth	FOxcroft 3-7133
MILLTOWN	Milltown Pharmacy, 21 No. Main St.	MIlltown 8-0081
MILLVILLE	Richard H. Knowles Pharmacy, 600 No. High St.	TAylor 5-0721
MORRISVILLE, PA.	Pryor's Pharmacy, Bridge St. & Penna Ave.	Cypress 5-7416
MOUNT HOLLY	Mount Holly Pharmacy, 64 Main St.	AMherst 7-0453
NEWARK	Giannotto's Pharmacy, 195 First Ave.	HUmboldt 2-8220
NEWARK	Marquier's Pharmacy, Sanford and So. Orange Aves.	ESsex 3-7721
NEW BRUNSWICK	Bode Pharmacy, 120 French St.	KIlmer 5-2676
NEW BRUNSWICK	Tobin's Drug Store, 335 George St.	CHarter 9-0780
NEW BRUNSWICK	Zaiac's Pharmacy, 225 George St.	KIlmer 5-0582
OCEAN CITY	Selvagn's Pharmacy, 862 Asbury Ave.	OCean City 3535
ORANGE	Highland Pharmacy, 536 Freeman St.	ORange 3-1040
PASSAIC	Wollman Pharmacy, 143 Prospect St.	PRescott 9-0081
PATERSON	Vallario's Pharmacy, 357 Totowa Ave.	ARmory 4-2139
PAULSBORO	Nastase's Pharmacy, 762 Delaware St.	PAulsboro 8-1569
PENNSAUKEN	Thor's Rexall Drugs, 4919 Westfield Ave.	NOrmandy 2-0848
PRINCETON	The Thorne Pharmacy, 168 Nassau St.	WAlnut 4-0077
RAHWAY	Bell Drug Store of Rahway, Inc., 1552 Irving St.	FUlton 1-2000
RAHWAY	Kirstein's Pharmacy, 74 East Cherry St.	FUlton 8-0235

(Continued on following page)

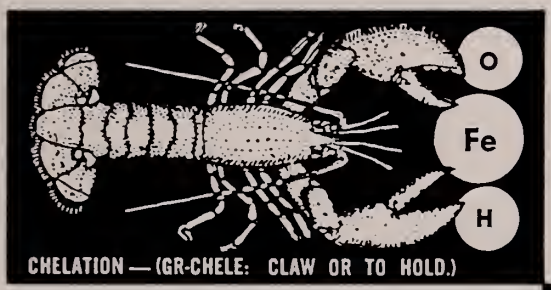
PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

(Continued from preceding page)

RIDGEFIELD PARK	Lloyd's Prescriptions, 209 Main St.	DIamond 2-8383
RUMSON	Rumson Pharmacy, W. E. Fogelson	842-1234
SOUTH AMBOY	Madura Pharmacy, 115 N. Broadway	PArkway 1-1732
SOUTH AMBOY	Peterson Pharmacy, 132 No. Broadway	PArkway 1-0137
TRENTON	Adam & Sickles, State & Prospect Sts.	OWen 5-6396
TRENTON	Episcopo's Pharmacy, Chambers & Liberty Sts.	EXport 3-3017
TRENTON	Foy's Drug Store, 3024 So. Broad St.	EXport 3-2367
UNION	Colonial Rexall Pharmacy, 1448 Morris Ave.	MUrdock 7-3100
UNION	Perkins Union Center Pharmacy	MUrdock 6-0877
WEST NEW YORK	Gemignani Pharmacy, 6129 Park Ave.	UNion 5-1296
WEST NEW YORK	The Owl Pharmacy, 6611 Bergenline Ave.	UNion 5-0384
WEST ORANGE	West Orange Pharmacy, 443 Main St.	ORange 4-9824
WRIGHTSTOWN	Bowen's Pharmacy, 152 Fort Dix Road	RAymond 3-2176



CHELATION — (GR-CHELE: CLAW OR TO HOLD.)

The FIRST Hematinic to Contain BOTH CHELATED IRON and CHELATED MINERALS Assuring a Truly Flavorful, Better Tolerated Iron Therapy.

ADVANTAGES —

Chelated Iron PLUS 4 Chelated Minerals • High Therapeutic Effectiveness • Less Irritation — even on empty stomach • No Tooth Stain • Less Toxic • B-Vitamins for Added Hemopoietic Activity • Pleasant Flavor • Economical

KELATRATE

LIQUID HEMATINIC

CHELATED IRON-MINERALS and VITAMINS

FORMULA —

Each 5 cc. (one teaspoonful) contains:

Iron (as Ferrous Betaine Citrate)	30 mg.
Cobalt (as Cobaltous Betaine Citrate)	0.1 mg.
Manganese (as Manganese Betaine Citrate)	1.0 mg.
Zinc (as Zinc Betaine Citrate)	1.25 mg.
Magnesium (as Magnesium Betaine Citrate)	6.0 mg.
Vitamin B-1	1.5 mg.
Vitamin B-2	1.2 mg.
Vitamin B-12	6.0 mcg.
Niacinamide	10 mg.
Panthenal	10 mg.

In an exceptionally pleasant tasting base.

Comprehensive literature and samples on request.

S. J. TUTAG & CO.
DETROIT 34, MICHIGAN
TUTAG

CLASSIFIED ADVERTISEMENTS

WANTED FOR SALE TO LET
SITUATIONS, ETC.

Send replies to box number c/o The Journal
P. O. Box 904, Trenton 5, N. J.

$3. for 25 words or less; additional words 5c each
Forms close 15th of the preceding Month.

POSITION OPEN—Full-time Director, Department of Medicine at the Newark City Hospital. Salary $20,000 to $22,500 for a 40-hour week. Qualifications are: Certification Board of Internal Medicine; medical school and clinical teaching experience. Write Joseph Levin, M.D., Medical Staff, Newark City Hospital, 65 Bergen Street, Newark 7, New Jersey.

OPHTHALMOLOGIST WANTED—To complete established Medical Building in South Jersey with six other practicing physicians. Call: HA 9-6300 till 5:00 p.m.

IMMEDIATE OPPORTUNITY—For General Practitioner to replace physician who just started residency. Large general practice with partner in a 4-year-old medical center including also internist, surgeon, obstetrician-gynecologist. Suburban area 15 miles from Philadelphia. Write Box No. 54, c/o The Journal.

RESIDENTS AND STAFF POSITIONS—Available for psychiatrists in 1600 bed neuropsychiatric hospital within 38 miles of Philadelphia. Intensive training program in hospital and affiliated institutions and clinics in Philadelphia associated with medical schools. Active research programs. Salary for career residents up to $10,635 per annum; for staff psychiatrists up to $17,200. Inquire, Hospital Director, V.A. Hospital, Coatesville, Pennsylvania.

YOUNG WELL-TRAINED PHYSICIAN—To join a busy practice in suburban New Jersey. Beautiful new building now under construction. No investment required. Up to $12,000 for the right man. Early partnership anticipated. Mostly medical and pediatrics. Some obstetrics and ample surgery available. Write now to D. F. GEARING ASSOCIATES, Business Consultants to the Medical Profession, 11 Court Street, White Plains, New York.

PHYSICIANS WANTED—Male and female, licensed, for children's camps, July-August. Good salary, free placement. 350 member-camps. Department p, Association Private Camps, 55 West 42nd Street, New York 36, New York.

OBSTETRICIAN-GYNECOLOGIST—Age 31, Board eligible, university trained. Desires association. Write Box 51, c/o The Journal.

INTERNIST—30 years old. Board Eligible. Medical school trained. Seeks association or practice New York or New Jersey. July, 1963. Write Box 38, c/o The Journal.

POSITION WANTED—Medical Assistants and Secretaries. Laboratory and X-Ray Techs. Well-trained and highly-qualified personnel (male and female) available. Phone CH 2-2330, Ext. 17, Placement Department, or write Physician Director, Eastern School for Physicians' Aides, Department 7, 85 Fifth Avenue, New York 3, New York.

PRACTICE-MANAGEMENT CONSULTANT—Will help you increase your productivity and retain more of your earnings. Our thorough analysis and detailed recommendations will help you improve your income/expense ratio, practice efficiency, retirement planning. Special attention to special problems. Reply Professional Business Consultants, 17th floor, 1 Liberty Street, New York 5, New York; or phone 212 HA 2-1536.

UPPER MONTCLAIR OFFICE TO SHARE—Air-conditioned. Recently occupied by Internist. 500 ma., X-ray, EKG and lab. available. Call PI 4-3636.

MEDICAL PRACTICE FOR SALE—In Bridgeton, New Jersey. Excellent, long-established. Air-conditioned, fully equipped modern offices, X-ray, etc. Home included. Write to Mrs. Helen Korican, 188 North Pearl Street, Bridgeton.

RADIOLOGICAL PRACTICE FOR SALE—Paterson, New Jersey, for the cost of office building, diagnostic, and therapy equipment, lead-lined rooms; 2 tenants' rentals more than enough to cover taxes and other expenses. Reasonable terms. Write Box No. 49, c/o The Journal.

PRACTICE AND HOME FOR SALE—Busy young general practitioner, retiring to go into fulltime research, wishes to sell his $30,000 practice and his beautiful combination home-office in rapidly growing area in central New Jersey. This is an ideal opportunity for a physician who wants to be busy right away with a beautiful home-office and complete equipment. Write for complete details to: D. F. GEARING ASSOCIATES, Business Consultants to the Medical Profession, 11 Court Street, White Plains, New York.

FOR SALE—Home-office. Superb northern Bergen County, New Jersey location. Very comfortable, four-bedroom house. Office area is new construction with parking facilities. Telephone NO 4-4155.

RENT OR SALE—Active general practice in New Jersey shore area. Can introduce. Leaving to specialize. Equipped office and residence. Negotiable terms. Write Box 50, c/o The Journal.

CLASSIFIED ADVERTISEMENTS

HOUSE FOR SALE—Roseville Avenue, Newark. Doctor's office, first floor; living quarters, second and third floors. HU 2-6655.

FOR SALE—Retiring doctor's office equipment: General Electric X-ray, 100 Ma., accessories, Wappler short wave, Jone's metabolism, instruments, etc. Reasonable. Irvington. Call ES 3-9117.

WEST ESSEX MEDICAL CENTER—Near new Korvette and Essex Green Shopping Centers; new hospitals; projected thruway. 2 suites remaining. Excellent for Ob-Gyn and specialties. Write Stanley S. Fieber, M.D., 588 Eagle Rock Avenue, West Orange, New Jersey. Call: RE 1-0011.

OFFICES FOR RENT—Equipped offices of deceased general practitioner. Wonderful opportunity. For summer season or year round. Will introduce. Stanley Hornstine, 4004 Pacific Avenue, Wildwood, New Jersey.

FOR RENT—2 suites of offices for medical profession, unequipped. Area needs general practitioner and specialist. Fine residential area on well-traveled routes 202-206. Somerville 1 mile. Contact B. Lewin, 722-6666.

OFFICE FOR RENT—Irvington, New Jersey, opposite hospital, was physician's office for over 20 years. Records of recently deceased physician available. Will rent either fully equipped or unequipped. Bus line stops at door. Phone SO 3-3663 or SO 3-0277.

FOR RENT—Office Space. M. A. Shinefield, M.D., 675 Broadway—corner 30th Street—Paterson, New Jersey. LA 3-1213.

FOR RENT—Doctor wanted for office in Union County: ground floor; will alter to suit; rent reasonable. Phone owner weekdays after 12 noon at 789-1333.

WHAT WOULD HAPPEN TO YOUR PRACTICE . . . IF NO PATIENT EVER CAME TO SEE YOU AGAIN?

If you are hospitalized, or disabled, for a long time — the results could be much the same!

PROTECT YOURSELF against "Loss of Time" with the broad new protection available from "The Doctors' Company". Send coupon below TODAY for full information.

PHYSICIANS MUTUAL INSURANCE CO.
formerly
Physicians Casualty and Health Associations
"The Doctors' Company"
Insuring Physicians & Dentists for 60 years.

Physicians Mutual Insurance Company
115 So. 42nd Street
Omaha 31, Nebraska

Please send details on your "Loss of Time" policy.

NAME_____ AGE_____

ADDRESS_____

CITY_____ STATE_____

FOR RENT—Bergen County, New Jersey. Growing area near Pascack Valley. Good Samaritan and Spring Valley Hospitals. Approximately 700 sq. ft. Will lay out as desired, central air-conditioning, beautiful corner, parking, all conveniences. Phone: GE 8-4350 or TW 1-2505.

PROFESSIONAL SUITE—New building, ultra modern, air-conditioned, A-1 location, Linden-Roselle line (Union County). Immediate possession. Modest rental. Milmark Agency, CH 5-2700.

RADON • RADIUM

SEEDS • IMPLANTERS • CERVICAL APPLICATORS

THE RADIUM EMANATION CORPORATION

GRAYBAR BUILDING • NEW YORK 17, N. Y.

Wire or Phone MUrray Hill 3-8636 Collect

in severe respiratory infections
refractory to other measures.

CHLOROMYCETIN®

(chloramphenicol, Parke-Davis)

for established clinical efficacy against susceptible organisms[1-]



In Friedlander's Pneumonia[3,13]

Although the prognosis in Friedlander's pneumonia is poor, treatment with CHLOROMYCETIN has shown a good response when susceptible strains of *Klebsiella pneumoniae* are incriminated.

In *Hemophilus Influenzae* Pneumonia[3,4,13,14]

Because the invading organism is usually sensitive to CHLOROMYCETIN, this agent is generally effective in pneumonias caused by *H. influenzae*.

In Staphylococcal Pneumonia[1-8,13]

CHLOROMYCETIN continues to remain effective against many resistant strains of staphylococci, and—alone or in combination with other antibiotics—should be considered when other antistaphylococcal drugs are ineffective.

In Acute Epiglottitis[4,10,11]

This condition is most often caused by *H. influenzae,* most strains of which are sensitive to CHLOROMYCETIN. Therapy should be instituted at once, since the disease may progress from the first symptoms to a severe respiratory obstruction in four to six hours.

In Pneumonias Due to Gram-negative Bacilli[9]

Because of its broad-spectrum activity, CHLOROMYCETIN is often effective in pneumonias caused by sensitive strains of *Aerobacter, Proteus* of various species, *Paracolobactrum,* and other gram-negative pathogens encountered with increasing frequency in serious respiratory tract infections.

In Staphylococcal Empyema[12]

The infiltrating lesions of staphylococcal empyema are often difficult to eradicate. While CHLOROMYCETIN should only be used when the infection has been resistant to treatment with other antistaphylococcal drugs, therapy with CHLOROMYCETIN, in conjunction with surgical procedures, will often bring favorable results.

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals© of 250 mg., in bottles of 16 and 100. See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections such as colds, influenza, or viral infections of the throat, or as a prophylactic agent.

Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Thacher, H. C., & Fishman, L.: *J. Maine M. A.* **52**:84, 1961. (2) Hopkins, E. W.: *Postgrad. Med.* **29**:451, 1961. (3) Hall, W. H.: *M. Clin. North America* **43**:191, 1959. (4) Krugman, S.: *Pediat. Clin. North America* **8**:1199, 1961. (5) Ede, S.; Davis, G. M., & Holmes, F. H.: *J.A.M.A.* **170**:638, 1959. (6) Wolfsohn, A. W.: *Connecticut Med.* **22**:769, 1958. (7) Calvy, G. L.: *New England J. Med.* **259**:532, 1958. (8) Hendren, W. H., III, & Haggerty, R. J.: *J.A.M.A.* **168**:6, 1958. (9) Cutts, M.: *Rhode Island M. J.* **43**:388, 1960. (10) Berman, W. E., & Holtzman, A. E.: *California Med.* **92**:339, 1960. (11) Vetto, R. R.: *J.A.M.A.* **173**:990, 1960. (12) Sia, C. C. J., & Brainard, S. C.: *Hawaii M. J.* **17**:339, 1958. (13) Rosenthal, I. M.: *GP* **17**:77 (March) 1958. (14) Gaisford, W.: *Brit. M. J.* **1**:230, 1959.

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan

03863

specific for anxiety & tension

Librium

The singular specificity of Librium in controlling anxiety and tension has proven to be an advantage in a wide range of disorders characterized by anxiety of varying degrees. Notably effective in patients whose symptoms are primarily emotional, Librium is equally valuable when organic disease is aggravated or prolonged by accompanying anxiety. Coupled with its effectiveness is an outstanding record of safety. Librium has few, if any, of the unwanted side effects associated with tranquilizers and daytime sedatives—no extrapyramidal effects, no autonomic blocking, and no dulling of mental alertness. Consult literature and dosage information, available on request, before prescribing.

the successor to the tranquilizers

LIBRIUM® Hydrochloride—7-chloro-2-methylamino-5-phenyl-3H-1,4-benzodiazepine 4-oxide hydrochloride

ROCHE

ROCHE

ANNUAL MEETING — MAY 11 - 15, 1963

HADDON HALL, ATLANTIC CITY

THE Journal OF THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since 1904
Copyright 1963 by The Medical Society of New Jersey

Entered as second-class matter Sept. 5, 1906, at the post office, Orange, N. J., under Act of March 3, 1879
Second Class Postage Paid at Orange, N. J.

LIBRARY

VOL. 60, No. 4 APRIL, 1963 30c — $3.00 PER YEAR

CONTENTS—Pages 143 to 180

EDITORIALS—	Page
On the Boardwalk in Atlantic City	143
Physicians' Responsibilities in Child Abuse	143
Our New Dress	144
PSYCHOSOMATIC PROFILE	145
ANNOUNCEMENTS	146
BOOK REVIEWS	147

ANNUAL MEETING PROGRAM—	Page
Daily Schedule	150
Dinner-Dance	151
House of Delegates	151
Reference Committees	152
Motion Picture Theatre	153
Scientific Section Meetings	155
Educational Exhibits	166
Scientific Exhibits	167
Technical Exhibits	172
Golden Merit Award	177
WOMAN'S AUXILIARY ANNUAL MEETING	178
RESPIRATORY DISEASE ABSTRACTS	179

Roster of Officers, Advertising Page 3A

The Medical Society of New Jersey Endorsed Plans of

ACCIDENT AND HEALTH INSURANCE
MAJOR MEDICAL EXPENSE INSURANCE
TERM LIFE INSURANCE

****SIX POINT, HIGH LIMIT ACCIDENT INSURANCE**
(Accidental Death, Dismemberment and other Accident Benefits)

Income Protection (Accident and Sickness Insurance)

$1,200 a month new maximum Basic total disability benefit

ACCIDENT: from 1st day, up to 5 years (Partial Accident Disability, half benefit up to six months)
SICKNESS: from 8th day, up to 2 years

$600 a month new maximum Extended total disability benefit, continuing benefits beyond basic coverage.

ACCIDENT: extended to LIFE
SICKNESS: extended through SEVENTH year

Major Medical

$10,000 maximum for Covered Expenses for each accident or sickness, covering member, spouse, and eligible children. $500 deductible, 20% co-insurance.

Life

$10,000 to **$50,000** of Convertible Term Life Insurance.
(Guaranteed exchangeable at any time into Permanent Cash Value life insurance)

Applications for initial $10,000 policy and additional $10,000 policies up to $50,000 total under this plan considered during the month of November each year*.

** **SIX POINT, HIGH LIMIT ACCIDENT INSURANCE**

Up to $200,000 Six Point, High Limit Accident Insurance, covering accidental death, dismemberment, loss of sight, total and permanent disability, exposure and disappearance for member.

Up to $100,000 for spouse (without disability benefit).

Applications are subject to age limits and other company rules and regulations for acceptance of risks. New members have special privileges during the first few months of membership; ask for specific details if you were recently elected and have not received notification from us.

Information and claim service are as close as your telephone.

E. & W. BLANKSTEEN

E. & W. Blanksteen Agency, Inc.

75 MONTGOMERY STREET JERSEY CITY 2, NEW JERSEY

DElaware 3-4340

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATON, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.
EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154
(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

OFFICERS

President, Louis S. Wegryn, M.D. ..... Elizabeth
President-Elect, Jerome G. Kaufman, M.D. ..... Maplewood
First Vice-President, Charles H. Calvin, M.D. .. Perth Amboy
Second Vice-President, John J. Bedrick, M.D. ..... Bayonne
Secretary, Marcus H. Greifinger, M.D. ..... Newark
Treasurer, Daniel F. Featherston, M.D. ..... Asbury Park

Mr. Richard 1. Nevin, *Executive Director* ..... Trenton
Mrs. Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton

TRUSTEES

Samuel J. Lloyd, M.D., *Chairman* (1963) ..... Trenton
Nicholas A. Bertha, M.D., *Secretary* (1965) ..... Wharton
Louis S. Wegryn, M.D. ..... Elizabeth
Jerome G. Kaufman, M.D. ..... Maplewood
Charles H. Calvin, M.D. ..... Perth Amboy
John J. Bedrick, M.D. ..... Bayonne
Marcus H. Greifinger, M.D. ..... Newark
Daniel F. Featherston, M.D. ..... Asbury Park
Ralph M. L. Buchanan, M.D. ..... Phillipsburg
Louis F. Albright, M.D. (1964) ..... Spring Lake
Louis K. Collins, M.D. (1964) ..... Glassboro
Thomas C. DeCecio, M.D. (1965) ..... Cliffside Park
Joseph P. Donnelly, M.D. (1963) ..... Jersey City
Lloyd A. Hamilton, M.D. (1965) ..... Lambertville
Frank J. Hughes, M.D. (1963) ..... Gloucester
Joseph R. Jehl, M.D. (1963) ..... Clifton
Emanuel M. Satulsky, M.D. (1964) ..... Elizabeth
Carl N. Ware, M.D. (1965) ..... Ocean City

COUNCILORS

First District (Essex, Morris, Union, and Warren Counties) ..... Henry L. Hermann, M.D., Phillipsburg (1963)
Second District (Bergen, Hudson, Passaic, and Sussex Counties) ..... John L. Olpp, M.D., Englewood (1965)
Third District (Hunterdon, Mercer, Middlesex, and Somerset Counties) ..... Albert F. Moriconi, M.D., Trenton (1964)
Fourth District (Burlington, Camden, Monmouth, and Ocean Counties) ..... E. Vernon Davis, M.D., Moorestown (1963)
Fifth District (Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties) ... Isaac N. Patterson, M.D., Westville (1963)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell, M.D. (1964) ..... Asbury Park
William F. Costello, M.D. (1963) ..... Dover
Joseph P. Donnelly, M.D. (1964) ..... Jersey City
Marcus H. Greifinger, M.D. (1964) ..... Newark
Luke A. Mulligan, M.D. (1964) ..... Leonia
Isaac N. Patterson, M.D. (1963) ..... Westville

Alternates

F. Clyde Bowers, M.D. (1964) ..... Mendham
Frank J. Hughes, M.D. (1964) ..... Gloucester
Joseph R. Jehl, M.D. (1964) ..... Clifton
John F. Kustrup, M.D. (1964) ..... Trenton
Elton W. Lance, M.D. (1963) ..... Rahway
John L. Olpp, M.D. (1963) ..... Englewood

DELEGATES TO OTHER STATES

New York—William F. Costello, M.D. (1963) ..... Dover
Connecticut—Lloyd A. Hamilton, M.D. (1963) .. Lambertville
New York—G. Ruffin Stamps, M.D. (1963) .... Atlantic City
Connecticut—S. Eugene Dalton, M.D. (1963) ..... Ventnor

INFORMATION FOR READERS AND CONTRIBUTORS

The Journal is the official organ of The Medical Society of New Jersey, published monthly under the direction of the Committee on Publication. *The Journal* is released on or about the tenth of each month, and a copy is sent to each member of the Society.

Change of Address: Notice of change of address should be sent promptly to The Medical Society of New Jersey, P.O. Box 904, Trenton 5, New Jersey.

Communications: Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of any material in *The Journal*. All such communications should be directed to the Editorial Office of *The Journal*. The Publication Committee reserves the right to publish, reject, edit or abbreviate all communications submitted to it.

Contributions: Manuscripts submitted to *The Journal* should be typewritten, double-spaced on letter size (about 8¼ by 11 inch) paper and forwarded to the Editorial Office at the address below. The Publication Committee expressly reserves the right to reject any contributions, whether solicited or not; and the right to abbreviate or edit such contributions in conformity with the needs and requirements of *The Journal*. Galley-proofs of edited or abbreviated manuscripts will be submitted to authors for approval before publication. Every care will be taken with the submitted material, but *The Journal* will not hold itself responsible for loss or damage to manuscripts. Authors are required to submit original copies only, and are urged to keep carbon copies for reference. It is understood that material is submitted here for exclusive publication in this *Journal*.

Illustrations: Authors wishing illustrations for their articles will submit glossy prints or original sketches, from which cuts or plates will be made by *The Journal*. The cost of making such cuts will be borne by the author, who will, after publication, receive the cuts for his own use. The cost of these cuts varies with the size and type of the illustration. An estimate of the cost will be submitted to authors before the cuts are ordered.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY
P. O. Box 904, Trenton 5, New Jersey



For dramatic restoration

WINSTROL®

brand of STANOZOLOL

Oral anabolic therapy with the new physiotonic WINSTROL results in the restoration of the patient's positive protein metabolism; confidence, alertness and sense of well-being.

WINSTROL combines highest potency* with outstanding tolerance, stimulates appetite and promotes weight gain... restores a positive metabolic balance. WINSTROL reverses the catabolic effects of concomitant corticosteroid or ACTH therapy. WINSTROL rebuilds body tissue while it builds strength, confidence and a sense of well-being.

Dosage: Usual adult dose, 1 tablet t.i.d. before or with meals; young women, 1 tablet b.i.d.; children from 6 to 12 years, up to 1 tablet t.i.d.; children under 6 years, ½ tablet b.i.d. Available as scored tablets of 2 mg. in bottles of 100. For best results, administer Winstrol with a high protein diet.

Side Effects and Precautions: Prolonged administration can produce mild hirsutism, acne or voice change. In an occasional patient, edema has been observed and in young women the menstrual periods have been milder and shorter. These side effects are reversible. In patients with impaired cardiac and renal function, there is the possibility of sodium and water retention. Liver function tests may reveal an increase in bromsulphalein retention, particularly in elderly patients. In such cases, therapy should be discontinued. Although Winstrol has been used in patients with cancer of the prostate, its mild androgenic activity is considered by some investigators to be a contraindication.

With Winstrol, patients look better ...feel stronger—because they are stronger!

*ANIMAL DATA

Winthrop

Winthrop Laboratories, New York 18, New York



Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. USUAL DOSAGE: 1 TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving actio

SOMA®

(carisoprodol, Wallac

Wallace Laboratories, Cranbury, New Jerse



Deltasmyl®

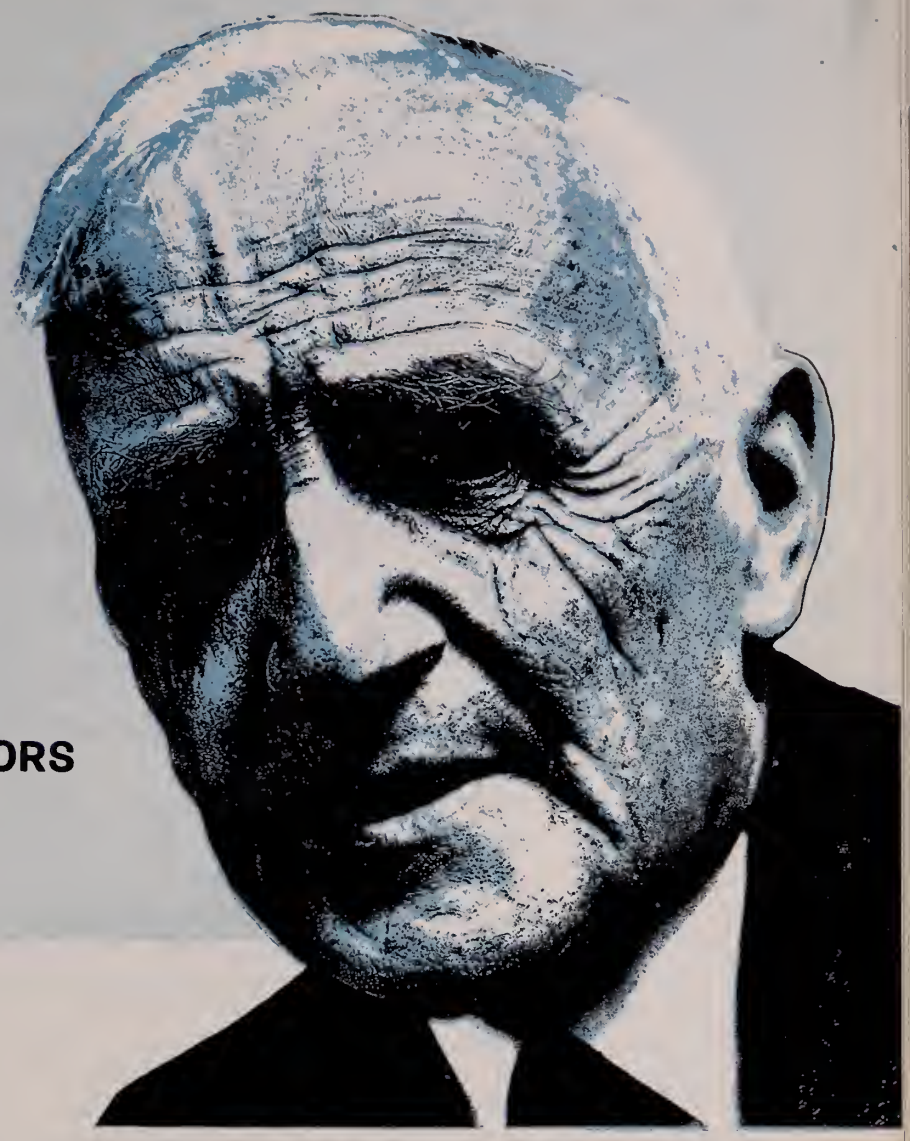
gives safer steroid protection from asthma

The aim of therapy in asthma should be relief of bronchospasm by means of decongestant and bronchodilating agents *plus prednisone*. When long-continued prednisone treatment is desirable, "the use of bronchodilator medication and other allied drugs should be continued *in order to decrease the dosage of the steroid hormone to a minimum.*" (Barach, A. L. and Bickerman, H. A.: Pulmonary Emphysema, Baltimore, The Williams and Wilkins Company 1956, p. 523.)

One DELTASMYL tablet provides the smallest, safest dose of prednisone (1.5 mg.), augmented by theophylline (120 mg.), ephedrine HCl (15 mg.), and phenobarbital (8 mg.), protects against asthma for about 4 hours. Not more than six tablets should be taken in 24 hours. Bottles of 50 tablets.

ROUSSEL — **Roussel Corporation,** 155 East 44th St., New York 17

For your elderly arthritic patients



AN EFFECTIVE
GERIATRIC
ANTIARTHRITIC
WITH ESSENTIAL
SAFETY FACTORS

safely indicated
– even in
the presence of
HYPERGLYCEMIA

PABALATE-SF may be prescribed with confidence to elderly arthritics—even in the presence of hyperglycemia—because of its widely recognized **Safety Factors:** (1) its potassium salts cannot contribute to sodium retention; (2) its enteric coating assures gastric tolerance; and (3) its use is free from the serious reactions in diabetic patients sometimes noted during therapy with steroids or pyrazolone derivatives. As for effectiveness, it has been found "superior to aspirin in the treatment of chronic rheumatic disorders."[1]

Each persian-rose enteric-coated tablet contains: potassium salicylate, 0.3 Gm.; potassium para-aminobenzoate, 0.3 Gm.; ascorbic acid, 50 mg.

1. Ford, R. A., and Blanchard, K. P.: J.-Lancet 78:185, 1958.

Precaution: Occasionally, mild salicylism may occur, but this responds readily to dosage adjustment. In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Supply: Bottles of 100 and 500 enteric-coated tablets.

Pabalate®-SF

Robins

(the new, convenient way to prescribe Pabalate-Sodium Free)

A. H. ROBINS COMPANY, INC., RICHMOND, VIRGINIA



IDYLEASE

A charming convalescent home, located on a beautiful 110-acre estate, fully licensed by the New Jersey Department of Institutions and Agencies, approved for listing by the American Hospital Association, eligible for Blue Cross Convalescent care benefits, 24 hour nursing care, X-ray department, laboratory, therapeutic pool, registered physiotherapist, recreational and occupational therapy. Complete medical facilities for the rehabilitation of convalescent cases and those in need of prolonged nursing care.

Open staff with consultant specialist services available. Orders of private physicians carefully followed by resident physicians, with complete reports rendered frequently.

REASONABLE RATES — INQUIRIES INVITED

Idylease Convalescent Home

UNION VALLEY ROAD - - - - NEWFOUNDLAND, NEW JERSEY

OXBOW 7-3311

Solfoton®

for mild, continuous sedation

Each tablet (or capsule) contains 16 mg. phenobarbital blended with 65 mg. Bensulfoid®. The Bensulfoid is an inert diluent present to permit slow absorption of the phenobarbital. The usual dosage is one tablet or capsule after meals and at bedtime. Solfoton is especially adapted to prolonged use because of its virtual freedom from depression and other side effects. Contra-indications: identical to those of ¼ gr. phenobarbital.

REFER TO PDR

Poythress, White Section, Page 808 (1963 edition) and Product Identification Section

COMPLETE INFORMATION AND CLINICAL SAMPLES SENT UPON REQUEST

Dispensed in bottles of 100 and 500 tablets or capsules

WM. P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856



BLUE SHIELD
-- an opportunity!

Blue Shield offers each of its 6,700 Participating Physicians in New Jersey an opportunity to do something specific about the future of medical care in America.

The very fact that physicians participate in Blue Shield is a statement of their belief in voluntary prepayment medical care. To take full advantage of the opportunity offered by Blue Shield most physicians do more than just participate. They make certain that their subscribing patients receive the full benefits of their contracts. By doing this they help to make Blue Shield a symbol of protection against economic catastrophe and a guarantee of the highest quality of medical care under the free enterprise system.

And the one New Jersey physician in five who has not yet joined Blue Shield can help to meet today's opportunity — by participation.



BLUE SHIELD®
Medical-Surgical Plan of New Jersey
500 Broad Street, Newark

Milestones in Nutrition

1911

when riboflavin was missing...

. . . they turned to milk. In 1911 Osborne and Mendel prepared a "synthetic" milk from purified chemicals. But their diet lacked something found in natural milk. Years later this substance was identified as riboflavin.

This vitamin has been so strongly associated with milk that in some countries it is called lactoflavin. Of the four food groups, milk and other dairy foods make the largest contribution to our total intake. When consumed as part of an adequate diet . . .

. . . 3 or 4 glasses for children

. . . 2 glasses for adults

. . . milk provides ½ of the riboflavin required daily.

Riboflavin functions in enzymes catalyzing the oxidation of fats, carbohydrates and proteins, thereby releasing energy for use by the cells. Only occasional cases of riboflavin deficiency are seen. These are usually associated with poor eating habits . . . alcoholism . . . fad diets.

As they have in the past, milk and other dairy foods will continue to play a vital role in the nutritional welfare of our people.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.



Since 1915 . . . promoting better health through nutrition research and education

NATIONAL DAIRY COUNCIL

a non-profit organization

202 EAST 44TH STREET • NEW YORK 17, NEW YORK

AVAILABLE ON REQUEST: Reprints of this series of messages on "MILESTONES IN NUTRITION" and "NUTRITION HANDBOOK FOR FAMILY FOOD COUNSELING" booklet

Trocinate®

Brand of Thiphenamil HCl.

FOR DIVERTICULITIS, MUCUS COLITIS,

IRRITATIVE DIARRHEA, IRRITATIVE URETERITIS,

BLADDER SPASM

*T*rocinate is a musculotropic antispasmodic with no appreciable anticholinergic action. It relieves spasms of the lower bowel and genito-urinary tract by direct action on the contractile mechanism of smooth muscles. The absence of any appreciable action on the autonomic nervous system eliminates the usual side-effects. It may be safely used in glaucoma. Each tablet contains 100 mgs. Trocinate HCl.

USUAL DOSAGE: 2 tablets, 4 times a day. Maintenance dosage is frequently lower.

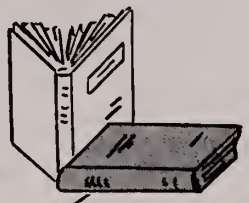
Dispensed in bottles of 40 and 250 tablets.

WM. P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856

SAUNDERS BOOKS

Valuable to the Physician



New (2nd) Edition!

Nadas — Pediatric Cardiology

Here is penetrating insight into the differences and peculiarities of diagnosis and treatment of heart disease in children as opposed to adults. Primary emphasis is on effective office management. Topics range from *angiocardiography* to *anesthesia for children with heart disease.* Differential diagnosis of murmurs is extensively covered. For such disorders as acute rheumatic fever, atrial septal defects, etc., you'll find details on: *incidence, anatomy, physiology, pathology, clinical picture, course and prognosis, differential diagnosis,* plus every aspect of *treatment.* For this *New (2nd) Edition* recent refinements in diagnostic techniques are fully covered. Revised criteria for surgical intervention and recently developed surgical techniques are presented. New, improved electrocardiograms are included among the new illustrations.

By Alexander S. Nadas, M.D., F.A.C.P., Assistant Clinical Professor of Pediatrics, Harvard Medical School; Cardiologist, The Children's Hospital; Physician, Sharon Cardiovascular Unit, Children's Medical Center, Boston. About 768 pages, 6⅜″ x 9¾″, with about 529 figures. About $16.00. *New (2nd) Edition—Ready May 1*

New (2nd) Edition!

Hinshaw and Garland — Diseases of the Chest

In this fully revised *New (2nd) Edition,* chest diseases are presented concisely and understandably to give you thorough step-by-step details of management. Under each disease the authors discuss: *background, incidence, statistical distribution, diagnosis, symptoms, pathology and classification, radiologic appearance, treatment and prognosis.* Important sections cover topics ranging from *bronchial asthma, bacterial and viral pneumonia, etc., to foreign bodies in the larynx and tracheobronchial tree, and coccidioidomycosis.* In this new edition you'll find a completely new section on *Pulmonary Function* and a marked expansion of the material on *Carcinoma of the Lung.* Many new chest films have been added. Chapters on *bronchitis* and *emphysema* are extensively re-written and expanded. The entire book is up-dated throughout.

By H. Corwin Hinshaw, M.D., Ph.D., D.Sc., Clinical Professor of Medicine; and L. Henry Garland, M.B., B.Ch., MD., Clinical Professor of Radiology, University of California School of Medicine, San Francisco. About 800 pages, 7″ x 10″, with about 650 illustrations on 312 figures. About $20.00. *New (2nd) Edition—Ready May 1*

New (2nd) Edition!

Reed — Counseling in Medical Genetics

This up-to-date *New (2nd) Edition* is packed with specific answers for the questions your patients ask you about heredity. Thousands of physicians profited from the first edition of Dr. Reed's book. He gives you concise facts on the chances of a disease or abnormality being transmitted from parent to child. Almost every chapter is devoted to a common genetic problem.

You'll find lucid advice on the problems of *mental retardation, mongolism, club foot, obesity, convulsive seizures, the schizophrenias, harelip and cleft palate, the central nervous system syndrome, disputed paternity, allergies, genetic effects of radiations, heart diseases, skin color, etc.* Illustrative examples show how the information is used in actual practice. They show types of requests for genetic information which have come to the author from agencies, physicians, parents, etc. The reply given to the questioner and the follow-up information obtained later is included.

Major attention is paid to diseases or abnormalities that appear with a frequency of better than one in 1,000 births. The Appendix lists practically all traits that may be transmitted to children. Dr. Reed gives a reference for each one—usually the most recent authoritative article known to him. You'll find listings of such traits as: *adrenal hyperplasia—Dandy-Walker syndrome—pancreatitis—retinal aplasia—Wilms' tumor—etc.*

Recent advances in the area of medical genetics have required a complete rewriting for this revision. New chapters cover *Cancers, The Chromosome Breakthrough,* and the *Environment.* The wealth of counseling experience available to the author has grown to over 2500 "cases," all handled at the Dight Institute for Human Genetics.

By Sheldon C. Reed, Ph.D., Director, Dight Institute for Human Genetics, The University of Minnesota. 278 pages, 5¾″ x 8″. About $5.50. *New (2nd) Edition—Just Ready!*

To Order Mail Coupon Below!

W. B. SAUNDERS COMPANY
West Washington Square Philadelphia 5

Please send when ready and bill me:

☐ Reed—*Counseling in Medical Genetics*.....About $5.50

☐ Hinshaw & Garland—*Diseases of the Chest*.....About $20.00

☐ Nadas—*Pediatric Cardiology*.....About $16.00

Name.....

Address.....

SJG 4-63

PROFESSIONAL LIABILITY INSURANCE PROGRAM

officially endorsed by

THE MEDICAL SOCIETY OF NEW JERSEY

PROTECTION for Professional Acts and Professional Premises Liability for members of The Medical Society of New Jersey by the First American Liability Insurance Company.

LOSS CONTROL. Your County Medical Review and Advisory Committee will evaluate malpractice cases and recommend the action which would be most favorable for the Medical Profession, the Defendant Doctor, the Patient and the Public. This program permits understanding of the complex problems involved in such cases and calls for close cooperation between the Medical Profession and Insurance Company.

MEDICO-LEGAL FORMS are furnished to each insured doctor to help in reducing claims or dissatisfied patients. Failure to use forms does not affect the doctor's insurance coverage or his eligibility for insurance.

INSURANCE COUNSELING. Insurance counseling and advice, available at all times, without cost, to help you with your Professional Liability insurance problems.

CANCELLATION. No policy will be cancelled or non-renewed without prior consultation between your Society and the Company and this is a matter of complete cooperation for the best interests of all concerned.

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY

Policies Guaranteed Non-assessable

Professional Liability Department

123 CLEVELAND STREET — ORANGE, NEW JERSEY

Joseph A. Britton, Manager — ORange 3-2575

Home Office: Wakefield, Mass.



in arthritis: vitamins are therapy

In dealing with the chronic stress of arthritis the physician often faces the problem of nutritional imbalance. High potency B and C supplementation is needed for rapid replenishment of tissue stores of these water-soluble vitamins. STRESSCAPS meet this need and help support the natural metabolic defenses in the disease. Supplied in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

STRESSCAPS®

Stress Formula Vitamins Lederle



HOW TO BE SURE
your young patients get the aspirin dosage you want them to have

The answer is Orange Flavored Bayer Aspirin for Children

The dosage is 1¼ grains per tablet. Mothers place such confidence in the Bayer name. And the new orange flavor is so fresh and smooth that children take it readily. (The grip-tight cap on the bottle helps keep them from taking it on their own.)

For professional samples, just write The Bayer Company, Dept. 112 1450 Broadway, New York 18, New York.



throughout the wide middle range of pain—control with one analgesic **PERCODAN®** *tablets*

(Salts of Dihydrohydroxycodeinone and Homatropine, plus APC)

In a comprehensive range of indications marked by moderate to moderately severe pain, PERCODAN *assures speed, duration, and depth of analgesia by the oral route... acts within 5 to 15 minutes... usually provides uninterrupted relief for 6 hours or longer with just 1 tablet... rarely causes constipation.*



Formula—Each scored yellow PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone HCl (Warning: May be habit-forming), 0.38 dihydrohydroxycodeinone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. acetophenetidin, and 32 mg. caffeine. **Also available:** PERCODAN®-DEMI, containing the complete PERCODAN formula but with only half the amount of salts of dihydrohydroxycodeinone and homatropine. Both products are on oral Rx in all states where laws permit. **Average Adult Dose**—1 tablet every 6 hours. **Side Effects and Contraindications**—Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to acetylsalicylic acid or acetophenetidin and in those with blood dyscrasias. *Literature on request.* **ENDO LABORATORIES Richmond Hill 18, New York**

Endo®

*U.S. Pats. 2,628,185 and 2,907,768

LEPTINOL·



Dispel the clouds of sunset years

Write for descriptive literature
Clinical trial samples available

Each Bi-layer tablet contains:

Pentylenetetrazol . . .	100 mg.
Niacin	50 mg.
Thiamine Hydrochloride	1 mg.
Ascorbic Acid	20 mg.

Dose: One or two tablets, three times daily.

LEPTINOL is a safe central nervous stimulant. LEPTINOL is highly effective in confused states of elderly patients. Incipient psychosis of senility, with its warning symptoms of loss of interest, egocentricity, hypochondriasis, insecurity and intolerance can frequently be ameliorated.

Even in the presence of degenerative organic pathology, LEPTINOL can markedly alleviate many of the mentally disturbing symptoms.

LEPTINOL has a very high index of therapeutic safety, with no liability of addiction or tolerance, virtually no contra-indications.

Primary action is a positive stimulation of the medulla, more pronounced in depressed states than in normal individuals. Higher brain centers are also stimulated, and to a lesser degree, the reflex activity of the cord.

THE VALE CHEMICAL CO., INC.
Allentown, Pennsylvania

VALE
Pharmaceuticals since 1922

In intestinal "grippe"

prompt 4 way check of diarrhea

- Curbs excessive peristalsis
- Adsorbs toxins and gases
- Soothes inflamed mucosa
- Provides intestinal antisepsis



POMALIN

TRADEMARK

Liquid

EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 cc. (tablespoon) contains:*

Sulfaguanidine U.S.P.	2 Gm.
Pectin N.F.	225 mg.
Kaolin	3 Gm.
Opium tincture U.S.P.	0.08 cc.
(equivalent to 2 cc. paregoric)	

DOSAGE: **Adults:** Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

SUPPLIED: *Bottles of 16 fl. oz. (raspberry flavor, pink color)*
Exempt Narcotic. Available on Prescription Only.

Winthrop LABORATORIES
New York 18, N. Y.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.



SCHEDULE YOUR TIME FOR A TOP SCIENTIFIC PROGRAM

at the

NEW YORK MEDICAL MEETING

MAY 15 - 17

Statler Hilton Hotel, New York City

* * *

Join in discussion with some of the nation's leading medical practitioners, including: Alexander Brunschwig of Memorial Hospital, New York City; Charles L. Dunham, Atomic Energy Commission, Washington, D. C.; Ray Gifford, Cleveland Clinic; William Likoff, Hahnemann Medical College & Hospital, Philadelphia, and

Ogelsby Paul, University of Illinois School of Medicine, Chicago; Howard B. Sprague, Massachusetts General Hospital, Boston; Shields Warren, Harvard Medical School at the New England Deaconess Hospital, Boston.

* * *

Attend These Important

GENERAL SESSIONS

MONDAY, 2:00 - 4:30 P.M.—Advances in Drug Therapy and Current Attitudes Toward Newer Medications.

TUESDAY, 9:30 A.M. - Noon—What Can the Family Doctor Do to Aid in Cancer Control?

WEDNESDAY, 2:00 - 4:30 P.M.—Management of the Complications of Atherosclerosis from the Biochemical Approach to the Patient as a Whole.

THURSDAY, 2:00 - 4:30 P.M.—Coronary Thrombosis: Management from the Prodromal Through Rehabilitative Stages.

FRIDAY, 9:30 A.M. - Noon—Radiation Effects and Safe Procedures in Medical Radiation.

Plus 23 Scientific Section Meetings
and Many New Scientific Exhibits . . .

* * *

**FOR COMPLETE PROGRAM DETAILS, WRITE NEW YORK MEDICAL MEETING,
MEDICAL SOCIETY OF THE STATE OF NEW YORK
750 3rd AVENUE, NEW YORK 17, N. Y.**



an orally active progestogen-estrogen combination

Duosterone®

anhydrohydroxyprogesterone . . . 10.00 mg.
ethinyl estradiol . . . 0.01 mg. } per tablet

Supplementing and supporting ovarian function, DUOSTERONE tablets can help release your patients from the anxiety, discomfort and inconvenience of functional amenorrhea and dysfunctional uterine bleeding.

DUOSTERONE therapy simulates and enhances the normal hormonal pattern of the secretory phase of the menstrual cycle, providing orally potent progesterone with ethinyl estradiol to prime the endometrium for adequate progestational response. Periodic progestational treatment with DUOSTERONE tablets aims at restoring the normal menstrual cycle—much as touching the pendulum starts a tightly wound clock.

Based on the classic studies of Zondek, Rakoff and others, DUOSTERONE provides dependable, trouble-free progestational therapy by mouth.

Bottles of 25 and 100 tablets with complete dosage instructions.

ROUSSEL

Roussel Corporation, New York 17, N.Y.

Fair Oaks
HOSPITAL
SUMMIT, NEW JERSEY

An 85 Bed Intensive Treatment Psychiatric Unit

— CERTIFIED BY —

THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

THE CENTRAL INSPECTION BOARD, AMERICAN PSYCHIATRIC ASSN.

OSCAR ROZETT, M.D.,
Medical Director

THOMAS P. PROUT, JR.,
Administrator

CRestview 7-0143

EYE ACHROMYCIN®

Tetracycline Lederle

ACHROMYCIN Ophthalmic Oil Suspension 1% instills tetracycline at full potency in liquid form at the site of superficial ocular infections. Highly concentrated broad-spectrum activity is localized at the site of infection, with a minimal occurrence of patient intolerance or tissue toxicity. Susceptible organisms are controlled earlier and more effectively.

Also available: ACHROMYCIN Eye and Ear Ointment 1% • ACHROMYCIN Ophthalmic Ointment 1% with Hydrocortisone 1.5% • ACHROMYCIN Ophthalmic Powder (Sterilized 25 mg., with sodium chloride 62.5 mg., and sodium borate 25 mg.)

When oral therapy is indicated

ACHROMYCIN® V

Tetracycline HCl with Citric Acid Lederle
Capsules—250 mg., 100 mg.



Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

from sodoku in India



to pharyngitis in New Jersey

there is a world of experience behind BRAND OF OXYTETRACYCLINE **Terramycin®**

Whether treating sodoku or a host of other infections, physicians throughout the world continue to rely on TERRAMYCIN for its outstanding safety, effectiveness and excellent tolerability. Not a single case of phototoxic reaction, blood dyscrasia or neurologic disturbance directly attributable to TERRAMYCIN has been reported in more than 3,000 clinical papers in the last 12 years. *In your practice, the next infection you see will very likely be "Terra-responsive."*

Sodoku is a synonym for the type of rat-bite fever occurring in the heavily populated Far East. The causative organism is *Spirillum minus,** a flagellated spirochete easily identified in dark-field preparations by its quick, darting motility. Besides the bandicoot,* indigenous to India and Ceylon, other rodents, ferrets and cats spread the disease. During the incubation period, which lasts from five to sixty days, the bite wound* heals, only to become inflamed and edematous with the onset of the acute stage. Fever, malaise, and a characteristic purplish maculopapular rash mark the eruption of the disease. Without treatment, relapses may recur periodically for four to six weeks.

**illustrated*

IN BRIEF The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. For complete information on Terramycin dosage, administration, and precautions, consult package insert before using. *More detailed professional information available on request.*

Science for the world's well-being®

Pfizer

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc.
New York 17, New York



Webcor Music Man

STEREOPHONIC HIGH FIDELITY TAPE RECORDER

...the ultimate in tape recorder performance!



PRICED AT only $198.80

- 2 and 4 track stereo operation
- 3 speeds—1⅞, 3¾, and 7½ ips.
- New, simplified "push-lever" operation
- Self-contained stereo record and playback
- Digital tape counter with pushbutton reset
- Dual volume controls—one for each channel
- Dual bass and treble controls

If you're the "one in a hundred" with a highly critical ear for perfection in sound, you'll be satisfied with nothing less than the new Webcor "MUSIC MAN" stereo tape recorder. And it's ever so simple to operate! Just push the lever up to "Play"... push it down to "Stop"... move it to the left to "Rewind"... to the right for "Fast Forward." Treat yourself to a thrilling new hearing experience. Ask for a demonstration today at—

Write for catalog to Exclusive N. J. Wholesale Distributors

ALL-STATE DISTRIBUTORS

INCORPORATED

457 CHANCELLOR AVE. NEWARK, N. J.

WAverly 3-4900

why let antihistamine drowsiness leave the job half-done?



It makes good sense to start your *active* allergy patients on Dimetane Extentabs. The response of a Dimetane-treated patient is eloquent proof that a *potent* antihistamine doesn't have to be a sedative, too. Most types of allergies respond quickly—most patients become symptom-free *and* stay on the job for Dimetane works with a very low incidence of significant side effects. Indeed, as one double-blind crossover study revealed, *with no greater incidence of sedation than placebo.** Also available as conventional tablets, 4 mg.; Elixir, 2 mg./5 cc.; Injectable, 10 mg./cc. or 100 mg./cc.

*Schiller, I. W. and Lowell, F. C.: New England J. Med. 261:478, 1959. A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

CONTINUOUS ACTION UP TO 10-12 HOURS

Dimetane® Extentabs®

(brompheniramine maleate, 12 mg.)

UNSURPASSED RELIEF OF ALLERGY SYMPTOMS
...WITH NO MORE SEDATION THAN PLACEBO*

in duodenal ulcer therapy



To dramatize the healing of peptic ulcer, our photographer burned a "lesion" into crumpled metal with a blowtorch, then repaired it and photographed the result.

solid results!

This is the kind of response you can expect with Robinul therapy.

Because Robinul's anticholinergic action is so specific, so intense, and so consistent, it provides a favorable internal environment for ulcer healing.

Positive suppression of gastric acid volume. Moeller[1] demonstrated that 2 mg. of Robinul decreases the volume of HCl secreted by 73% within one hour and 85% within two. Epstein[2] described Robinul's "intensive antisecretory action" as "exemplary."

Significant increase in gastric pH. In his studies comparing the effect of anticholinergics on gastric pH, Sun[3] found that the optimum effective dose of Robinul "... produced suppression of gastric acidity to pH 4.5 or higher in all 16 patients examined." Posey[4] reported "an excellent reduction of gastric acidity ... in 12 of 15 patients...."

Desirable antimotility effect. Young and Sun[5] found that although Robinul (given subcutaneously) demonstrated its ability to suppress antral motility, a 2 mg. oral dose "did not affect gastric emptying or intestinal transit time" in six patients with duodenal ulcer.

New freedom from side effects. Robinul has shown that an anticholinergic need not be plagued with a high percentage of side effects. Of 1705 patients in clinical investigations, many of whom were studied on above-normal doses, fewer than 7% experienced side effects of a moderate-to-severe degree, with only 3% requesting discontinuance of the medication.

PRESCRIBING INFORMATION:
Robinul and Robinul-PH have provided good to excellent results in 83.1% of 795 reported cases of peptic ulcer.

SIDE EFFECTS: Dryness of mouth, blurred vision, urinary difficulties, and constipation are seldom troublesome and may generally be controlled by reduction of dosage. Other unwanted effects such as rash have been reported, but only very rarely.

PRECAUTIONS: Administer with care to patients with incipient glaucoma. Contraindicated in acute glaucoma, prostatic hypertrophy, and in presence of urinary bladder neck obstruction or pyloric obstruction or stenosis with significant gastric retention. Robinul-PH is contraindicated in patients sensitive to phenobarbital or with advanced hepatic or renal disease.

REFERENCES: 1. Moeller, H.C.: Ann. New York Acad. Sc. 99:158, Feb. 28, 1962. 2. Epstein, J. H.: Am. J. Gastroent. 37:295, 1962. 3. Sun, D. C. H.: Ann. New York Acad. Sc. 99:153, Feb. 28, 1962. 4. Posey, E. L., Jr.: Am. J. Digest. Dis. 7:863, 1962. 5. Young, R., and Sun, D. C. H.: Ann. New York Acad. Sc. 99:174, Feb. 28, 1962.

A. H. Robins Co., Inc. Richmond 20, Virginia

Robinul®

ANTICHOLINERGIC

Brand of glycopyrrolate,* 1 mg. per tablet

Robinul®-PH

ANTICHOLINERGIC/SEDATIVE

Glycopyrrolate, 1 mg., and phenobarbital, ¼ gr. per tablet

*U. S. PATENT NUMBER 2,956,062

neither **stasis** nor **spasm,**
nor **tension**
stays this patient
from his
appointed rounds



DECHOLIN-BB®

. . . . . especially when
UPPER G.I. COMPLAINTS
have biliary implications

Each Tablet Contains:

for biliary/intestinal **stasis** → DEHYDROCHOLIC ACID 250 mg. (3¾ gr.)

for smooth-muscle **spasm** → BELLADONNA EXTRACT 10 mg. (⅙ gr.)

for nervous **tension** → BUTABARBITAL SODIUM 15 mg. (¼ gr.)

Average adult dose: 1 or, if necessary, 2 tablets three times daily. **Precautions:** Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction; caution drivers against possible drowsiness. **Side effects:** Dehydrocholic acid may cause transitory diarrhea; belladonna may cause blurred vision and dry mouth. **Contraindications:** Biliary tract obstruction, acute hepatitis, glaucoma, prostatic hypertrophy. **Available:** DECHOLIN-BB, bottles of 100 tablets. **Also:** DECHOLIN® with Belladonna (dehydrocholic acid, 250 mg.; belladonna extract, 10 mg.) and DECHOLIN® (dehydrocholic acid, 250 mg.), bottles of 100 and 500 tablets.

AMES
COMPANY, INC.

in

STAPH CONTROL





procedures... Mennen products have proven their quality in hospital use.

■ **Anti-Bacterial Genteel Baby Bath** with 1% Hexachlorophene. Genteel provides excellent asepsis for infant baths, hand scrubs and continued anti-bacterial skin care at home.

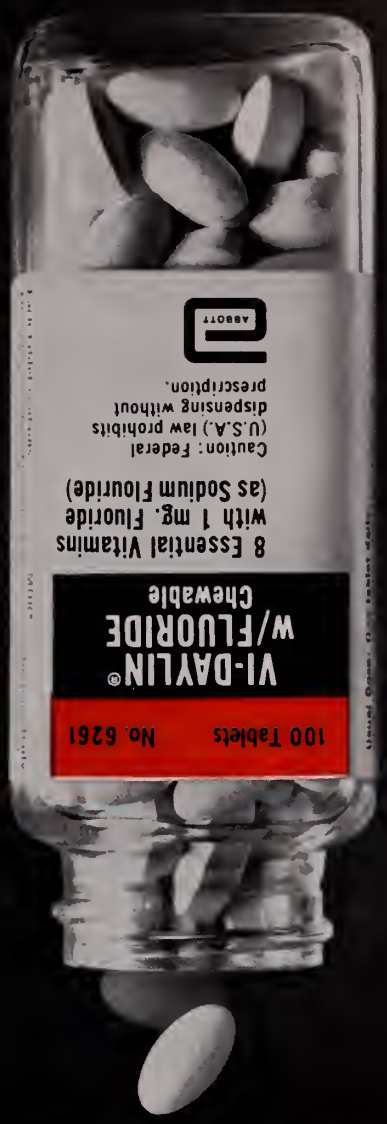
■ **Anti-Bacterial Baby Magic Skin Care** with Methylbenzethonium Chloride. Famous Baby Magic offers additional skin care and protection, yet does not destroy the hexachlorophene asepsis achieved with routine baths and hand scrubs. Soothes, helps control dry skin, diaper rash, miliaria.

Also available: Medicated Mennen Baby Powder—the comfort powder used in hospitals for infant skin care.

All Mennen Baby Products available in special hospital sizes; for prices, see your Mennen Representative, or write **The Mennen Company** Morristown, N. J. Ⓜ



If you don't have fluoride in your water...



...you should know about new Vi-Daylin® w/Fluoride with entrapped flavor

The evidence is in. More than 8,000 published reports verify the effectiveness and safety of fluoride as prophylaxis against dental caries. Yet most communities today are still without water fluoridation.

If you are in such an area, new Vi-Daylin w/Fluoride is an almost ideal means of supplementation for children. For three reasons:

1. Each tablet contains the equivalent of 1 mg. fluoride. This is the amount suggested for children three and over by the American Dental Association.*[1,2]

2. As in regular Vi-Daylin Chewable, your patient gets the benefit of *entrapped flavor*. This ingenious, double-coating process permits complete entrapment of raw vitamin tastes and odors—and keeps delicate flavoring oils fresh until the moment of use. Result: A tablet that tastes like citrus candy.

3. Sweetened with sugar-free Sucaryl®. Because Sucaryl is non-nutritive, it will not react with bacteria to form acids in the mouth.

Cost? No more than regular Vi-Daylin Chewable in economical bottles of 100.

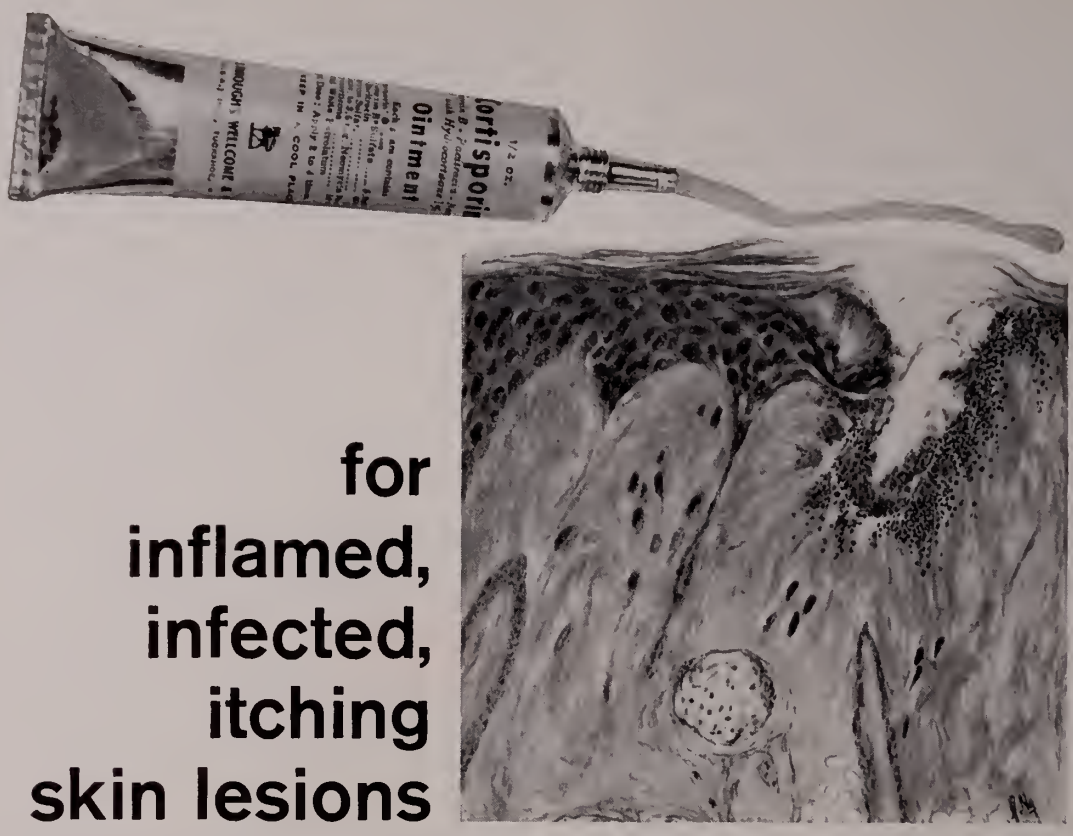
75TH ANNIVERSARY ABBOTT

1. Prescribing Supplements of Dietary Fluorides, Council of Dental Therapeutics, J.A.D.A., 56:591, April, 1958.
2. Fluoride Compounds, Accepted Dental Remedies, 27th Ed.:139, 1962.

VI-DAYLIN w/FLUORIDE—Multivitamins with Fluoride. SUCARYL—Abbott's Non-Caloric Sweetener.

*In areas where drinking water is substantially devoid of fluoride.

104213



for inflamed, infected, itching skin lesions

'CORTISPORIN'® OINTMENT
brand

anti-inflammatory / bactericidal / antipruritic

- relieves pain and itching
- reduces inflammation and edema
- provides bactericidal action against most gram-positive and gram-negative organisms, including **Pseudomonas aeruginosa**
- rarely sensitizes

General Indications: Wherever inflammation or infection occurs and is accessible for topical therapy, as in burns, wounds, skin grafts; and plastic, proctologic, gynecologic, or general surgical procedures.

Dermatologic Indications: Atopic, contact, stasis, infectious eczematoid, and lichenoid dermatitis; neurodermatitis, eczema, pyoderma; anogenital pruritus; primary dermatoses with or without secondary infection; external otitis.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms.

Available: In tubes of ½ oz. with applicator tip and ⅛ oz. with ophthalmic tip. Although the ⅛ oz. tube is intended for ophthalmic use, it may be used topically.

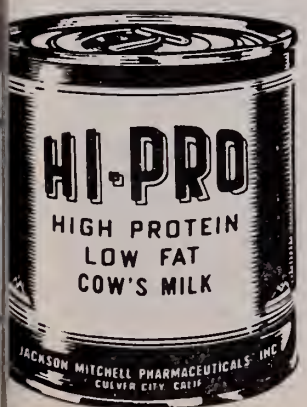
Each gram contains:

'Aerosporin'® brand Polymyxin B* Sulfate	5,000 Units
Zinc Bacitracin	400 Units
Neomycin Sulfate (equivalent to 3.5 mg. Neomycin Base)	5 mg.
Hydrocortisone	10 mg. (1%)
Special White Petrolatum	q.s.

*U.S. PAT. NOS. 2,565,057 AND 2,695,261

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

this can contained an effective help for infant diarrhea; celiac syndrome; fat intolerance_



Hi-Pro contains Protein 41%; at 14%; Lactose 35%. Available in 1-lb. and 2½-lb. cans.

AND IT'S FREE

SEND ME MY FREE SAMPLE OF HI-PRO, 2 OZ. SIZE

Mail to: Jackson-Mitchell Pharmaceuticals, Inc.
10401 Virginia Ave., Culver City, California
Babying Americans since 1934

Name _____

Address _____

City _____ Zone _____ State _____

CONGRATULATIONS

to

THE MEDICAL SOCIETY OF NEW JERSEY

on the occasion of its

197th ANNUAL MEETING

Public Service Electric and Gas Company

Thorazine® *is not an analgesic*

brand of chlorpromazine

but it can help you relieve the suffering of your patient in PAIN . . .

by reducing the anxiety and fear that intensify pain

by potentiating analgesics—enabling you to reduce narcotic dosage by 50 to 75%

and by controlling nausea and vomiting.

'Thorazine' is particularly useful in the severe pain seen in your cancer, surgical, and obstetrical patients. It is available in a wide variety of dosage forms, including injection, Spansule® sustained release capsules, suppositories, syrup and tablets.

For prescribing information, please see *PDR* or SK&F literature.

SK&F *Smith Kline & French Laboratories*

Photograph professionally posed.





Ortho Pharmaceutical Corporation

RARITAN, NEW JERSEY



excessive uterine bleeding*

"significant improvement..."[1]

duo-CVP®

(double-strength CVP)

In patients in whom there was "flooding" (associated with menorrhagia for which no organic cause could be isolated), non-hormonal therapy with duo-C.V.P. achieved "excellent" results as assessed by easy control of bleeding, improved sense of well-being, and ability to maintain normal activities. "In no case has there been any instance of side effects."[1]

The clinician attributes the anti-hemorrhagic effects of duo-C.V.P. to its apparent ability to restore normal small vessel structural integrity and function.

duo-C.V.P. and C.V.P.† have also been reported of value in the treatment of capillary bleeding associated with other gynecologic conditions such as threatened and habitual abortion, post-partum bleeding and functional menometrorrhagia.[2-5]

Each duo-C.V.P. capsule provides:	
CITRUS BIOFLAVONOID COMPOUND	200 mg.
ASCORBIC ACID (VITAMIN C)	200 mg.

Bottles of 50, 100, 500 and 1000 capsules.

†C.V.P. provides in each capsule 100 mg. of an exclusive citrus bioflavonoid compound and 100 mg. of ascorbic acid. Bottles of 100, 500 and 1000 capsules.

references: 1. Prueter, G. W.: Applied Therapeutics 3:351, 1961. 2. Taylor, F. A.: West J. Surg., Obstet. & Gynec. 64:280, 1956. 3. Ainslie, W. H.: Obstet. & Gynec. 13:185, 1959. 4. Pearse, H. A., and Trisler, J. D.: Clin. Med. 4:1081, 1957. 5. Clemetson, C. A. B., and Blair, L. M.: Am. J. Obst. & Gynec. 83:1269, 1962.

menorrhagia*

Samples and literature from

u. s. vitamin & pharmaceutical corp.

Arlington-Funk Laboratories, division • New York 17, N. Y.



so sorry...



we can't pay your tolls

However...There's a full 12 month or 12,000 mile guarantee with each new DATSUN. Compared with our leading competitor, DATSUN offers more of everything—longer guarantee, more horsepower, more speed, more doors (4), more passenger and trunk room, terrific economy! • Come in and test drive the new DATSUN. See for yourself why we dare to compare this beauty from Japan with all others. • Other models to choose from: 4 DOOR STATION WAGON $1816.— ½ TON PICK UP $1545.—FWD GP PATROL $2658.



$1616 P.O.E.*
12 MONTHS OR 12,000 MILES GUARANTEE
*Plenty Of Extras

"OPERATES ON A KEY AND SMALL CHANGE...MOSTLY FOR TOLLS."

DATSUN

NISSAN MOTOR CORP. IN U.S.A. 221 FRELINGHUYSEN AVE., NEWARK, N. J.

These 20 New Jersey DATSUN Dealers are at your service:

REICHLIN'S SPORT CENTER, Route No. 130 and Farnsworth Avenue, Bordentown
APGAR'S GARAGE, Route No. 206, Chester
OXFORD MOTORS, Route No. 46, East Paterson
SPREEN'S AUTO SALES, 458 Passaic Street, Hackensack
IMPERIAL IMPORT, 320 Haddon Avenue, Haddonfield
SUBURBAN POWER EQUIPMENT. 319 State Highway No. 10, Hanover
MODERN AUTO SALES, 575 Chancelor Avenue, Irvington
TOMS RIVER IMPORTED CARS, Route No. 37 and Central Avenue, Island Heights
WASHINGTON SALES, 370 Broad Street, Keyport
TOWNE AUTO SALES, 11B Fort Lee Road, Leonia
OXFORD MOTORS, 230 Route No. 17, Lodi
ZEMAN MOTORS, Route No. 17 and Ramapo Avenue, Mahwah
KINNEY MOTORS, INC., 1010 Broad Street, Newark
BIANCA MOTORS, INC., 316 Memorial Parkway, New Brunswick
FOREIGN CAR CO., Route No. 22, North Branch
WILLIAM JAY CLARK, 505 Somerset Street, North Plainfield
POMPTON AUTO SALES, Route No. 23, Pompton Plains
LAYNE MOTORS, INC., 465 Lehigh Avenue, Union
S. & S. MOTORS, Route No. 23, Wayne
HORNUNG AUTOMOTIVE SALES & SERVICE, 494 Valley Road, West Orange



Relieves Anxiety and Anxious Depression

The outstanding effectiveness and record of safety with which Miltown relieves anxiety and anxious depression—the type of depression in which either tension or nervousness or insomnia is a prominent symptom — has been clinically authenticated time and again during the past seven years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more often than any other tranquilizer in the world.

Miltown®

meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS® — 400 mg. *unmarked*, coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

WALLACE LABORATORIES / *Cranbury, N. J.*

Clinically proven in over 750 published studies

1. Acts dependably — without causing ataxia or altering sexual function
2. Does not produce Parkinson-like symptoms or liver damage
3. Does not muddle the mind or impair physical activity

STONY LODGE HOSPITAL

OSSINING-ON-HUDSON, N. Y.

Telephone 914 — WILSON 1-7400

STONY LODGE IS STAFFED AND EQUIPPED TO DO A COMPLETE CLINICAL AND LABORATORY DIAGNOSTIC EVALUATION OF PSYCHIATRIC PROBLEMS.

STONY LODGE maintains an extensive active treatment unit with complete facilities for the organic therapies, including coma-insulin; both regressive and conventional electro-shock therapy. Psychotherapy both analytically oriented and "short-term intensive" is available for those patients where the physical therapies are contra-indicated, but who require hospital care.

Established 1928

CAPACITY 61

Recreational and Occupational Therapy — Swimming Pool, Athletic Field, Tennis Court

TWENTY LANDSCAPED ACRES — GARDENS — PROMENADES

750 FEET ABOVE SEA LEVEL, OVERLOOKING THE HUDSON RIVER

28 MILES NORTH OF NEW YORK CITY

LEO J. PALMER, M.D., Medical Director

CHARLES A. BRIGHT, M.D.
Associate Director

MAURICE J. O'CONNOR, M.D.
Associate Director

FRANCIS M. HUBA, B.B.A.
Business Administrator

AR INC.

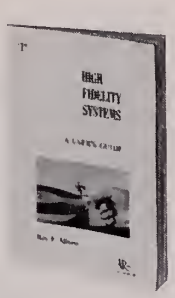
books et al

HIGH FIDELITY SYSTEMS—*A User's Guide*

by **Roy F. Allison**

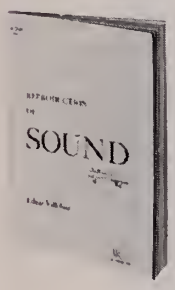
AR Library Vol. 1 70 pp., illus., paper $1.00

A layman's practical guide to high fidelity installation, this book describes and illustrates the assembly of a component reproducing system step by step. Roy F. Allison is chief of engineering at Acoustic Research, and former editor of **Audiocraft** magazine. We think that **High Fidelity Systems** will become a classic work for novices (and perhaps be consulted secretly by professionals).



REPRODUCTION OF SOUND by **Edgar Villchur**

AR Library Vol. 2 93 pp., illus., paper $2.00



Reproduction of Sound explains how components work rather than how to use them, but it presupposes no technical or mathematical background. Edgar Villchur is president and director of research of AR, former contributing editor of **Audio**, and former teacher in electronics at New York University. His book is for the layman with more than passing interest and patience, or for the serious student as a pre-engineering survey.

AR Needle Force Gauge $1.00



The same gauge that is supplied with AR turntables. It is an equal arm balance with weights to ¼ gram, accurate enough to be used at the plant, and complete with instructions and case.

ACOUSTIC RESEARCH, INC., 24 Thorndike Street, Cambridge 41, Massachusetts

Please send me the following:

_____ copies of Roy Allison's "**High Fidelity Systems—A User's Guide**" at $1 each.

_____ copies of Edgar Villchur's "**Reproduction of Sound**" at $2 each.

_____ AR needle force gauges at $1 each.

I enclose $_____in bills, money order, or check only. (All prices postpaid.)

NAME _____

ADDRESS _____

Data Sheet
CKMT 139

Cargille

CHECK LIST FOR MEDICAL TECHNOLOGY

	DATA SHEET CODE
BOILING STONES—Prevent bumping of boiling liquids. Available as assorted, large, medium and small mesh sizes.	BS
DISPOSABLE LABORATORY CONTAINER—A paper cup calibrated in ml. and oz. 100 ml and 400 ml sizes.	DSP
GRADUATED 8-10 TUBES—½" x 4½" long. Calibrated to 8 ml and in 10 equal parts.	ET
IMMERSION OIL — Non-drying. For oil immersion objectives. 3 types, each of different viscosity.	IO
KINGSBURY-CLARK ALBUMIN STANDARDS—For quantitative albumin in urine by precipitation with sulfosalicylic acid.	KC
LABELS, SELF-ADHESIVE — Consecutively numbered. Available in sets up to 5000. 100 per sheet. Label size ½ x 5/16".	SEQ
LOVINS FIELD FINDER — Relocate points of interest on slides under the microscope.	LFF
MAGNIFIERS — Tripod, triplets, illuminated. For gross examinations, dissection, and specimen preparation.	MAG
MICRO BEAKERS — 4 standard sizes —0.5 to 5 ml capacity. Excellent for weighing small amounts and then throwing in beaker and contents. No loss on transfer.	MB
PLASTIC BOXES—Molded polystyrene. 18 stock sizes. For storing small and large parts, equipment supplies, specimens.	PB

	DATA SHEET CODE
pH PAPERS—Long and short range in plastic dispensers and refill packs for medical and chemical work.	PH
QUATERNARY TEST PAPERS — Dispenser, envelopes or refill packs. Determine concentrations in 100--400 ppm. of sanitizing solutions.	QT
REAGENT GRANULES FOR ALBUMIN —A few mg. of sulfosalicylic acid crystallized on an inert plastic carrier precipitates albumin, if present, from 5-drop specimen.	RGA
SAMPLE STORAGE SETS—3 sizes. Partition boxes of vials with closures for systematic identification, handling and storage of samples and specimens.	SS
SAMPOULES—For sealing up to 8 ml. of sample hermetically in your laboratory. Also supplied in sample storage boxes.	SAM
SUGAR STANDARDS—For the quantitative determination of urinary sugar by the Benedict Picrate Method.	SUS
TISSUE FILES—A substantial, partitioned hinged-lid box for routine collection and storage of histiological embedment blocks.	TF
TURBIDIMETER—For visual detection of trace amounts of haze and suspended matter in solutions.	CLT
URINARY PRESERVATIVE TABLETS— For use when analysis may be delayed or specimens are mailed. 276 mg size for 1 - 2 oz; 95 mg. for 15-20 cc specimens.	UP
WEIGHING DISHES—Stainless steel. 65 mm diam. Matched to 1 mg. For balance work.	WD

Request Data Sheets and Prices by Sending Post Card with Name and Address.
List Code Letters for specific items or Request "CKMT DATA" for all items.
or Circle Codes on this Sheet and Mail.

CARGILLE SCIENTIFIC INC. — CEDAR GROVE, NEW JERSEY



A NEW CADILLAC AND ITS CLOSEST RIVAL

That's a fact! The only logical substitute for a new Cadillac is a Cadillac of greater vintage (like the black two-year-old in the picture above). At least, so many motorists feel this to be true that the car is always in demand. Consequently, a larger share of the initial investment is traditionally returned at resale time. Isn't it remarkable that the unduplicated pleasures of Cadillac ownership can be yours at a depreciation rate that is more favorable than that of any other car in the Cadillac price class? Why not plan to see and drive this new Cadillac soon?

VISIT YOUR LOCAL AUTHORIZED CADILLAC DEALER

The Morristown Rehabilitation Center

66 MORRIS STREET MORRISTOWN, NEW JERSEY

JEFFERSON 9-3000



NATHAN KAPLAN, M.D., Physiatrist
MARY E. JOHNSON, Chief Therapist

ANN G. McMANUS, R.N.
Director of Nursing Service

AUDREY E. TAHLMORE
Administrator

A 38-bed rehabilitation unit specializing in orthopedic and neurological disabilities. Speech therapy, Occupational therapy and psychological evaluation available.

- - - - - -

AMERICAN HOSPITAL ASSOCIATION ACCREDITATION
MEMBER NEW JERSEY LICENSED NURSING HOME ASSOCIATION



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE-MARK ®

indication:

accidental trauma



indicated:

Chymoral®

ORAL systemic anti-inflammatory enzyme tablet

92% Excellent/Good Results in 6,929 cases[1-4]

Whether the patient presents simple edema and inflammation from a sprained ankle or severe lacerations and bruises from a violent accident, immediate use of Chymoral cuts healing time. Chymoral modifies the inflammatory reaction, dissipates edema and blood extravasations, thus accelerating the body's natural reparative action.

controls inflammation, reduces swelling, relieves pain

1. Physicians' Reports to the Medical Department, Armour Pharmaceutical Company, 1961. 2. Beck, C., *et al.:* Clin. Med. 7:519, 1960. 3. Teitel, E. H., *et al.:* Indust. Med. *29*:150, 1960. 4. Billow, B. W., *et al.:* Southwestern Med. *41*:286, 1960.

CHYMORAL is an ORAL anti-inflammatory enzyme tablet specifically formulated for intestinal absorption. Each tablet provides enzymatic activity, equivalent to 50,000 Armour Units, supplied by a purified concentrate which has specific trypsin and chymotrypsin activity in a ratio of approximately six to one. ACTION: Reduces inflammation of all types; reduces and prevents edema except that of cardiac or renal origin; hastens absorption of blood and lymph extravasates; helps to liquefy thick tenacious mucous secretions; improves regional circulation; promotes healing; reduces pain. INDICATIONS: Chymoral is indicated in respiratory conditions such as asthma, bronchitis, rhinitis, sinusitis; in accidental trauma to speed absorption of hematoma, bruises, and contusions; in inflammatory dermatoses to ameliorate acute inflammation in conjunction with standard therapies; in gynecologic conditions such as pelvic inflammatory disease and mastitis; in obstetrics as episiotomies and breast engorgement; in surgical procedures as biopsies, hernia repairs, hemorrhoidectomies, mammectomies, phlebitis and thrombophlebitis; in genitourinary disorders as epididymitis, orchitis and prostatitis; in dental and oral surgery as fractures of the mandible or maxilla, difficult or multiple extractions, and alveolectomies. CONTRAINDICATIONS: None known. INCOMPATIBILITIES: None known. Antibiotics as well as generally accepted measures may be coadministered. SIDE EFFECTS: Mild gastric upsets, rarely encountered. DOSAGE: Recommended initial dose is two tablets q.i.d.; one tablet q.i.d. for maintenance. SUPPLIED: Bottles of 48 and 250 tablets. Issue: Rev. Jan., 1963

The true economy of proven effective dosage

ARMOUR PHARMACEUTICAL COMPANY

KANKAKEE, ILLINOIS

Originators of Listica®

Flavoring Improves Palatability of Acidophilus Milk

In the treatment of acne vulgaris and such gastro-intestinal disorders as simple chronic constipation and simple diarrhea, patient resistance to ingestion of Acidophilus may be controlled if flavor is improved by stirring 1 to 2 teaspoons of Jell-O powder into each glass of Acidophilus Milk before serving. Most popular flavors are raspberry, cherry, orange-pineapple, blackberry, and strawberry. For patients on low-calorie diets, substitute D-Zerta for Jell-O. Add a few drops of Sweeta or Sweet-10 to the flavored Acidophilus for a sweeter drink.

WALKER-GORDON ACIDOPHILUS

2% butterfat, made from Walker-Gordon Certified Milk cultured with 300-500 million acidophilus bacilli per ml. Available through leading milk dealers.

WALKER-GORDON CERTIFIED MILK FARM, Plainsboro, N. J.

SWinburne 9-1234 (N. Y. WAlker 5-7300; Phila. PEnnypacker 5-3465)

How Lyons Institute Serves the Medical Profession

For the past eleven years Lyons Institute of Medical, Dental and X-ray Technology has been training high school graduates to serve the medical profession as:

MEDICAL TECHNOLOGIST • MEDICAL TECHNICIAN • MEDICAL ASSISTANT
X-RAY TECHNICIAN • MEDICAL SECRETARY

Many hundreds of our graduates are employed by physicians, hospitals, clinics, laboratories, pharmaceutical concerns and private industry. If you are seeking qualified personnel in any one of the above fields, our free Placement Bureau is at your Service.

LYONS INSTITUTE of MEDICAL, DENTAL & X-RAY TECHNOLOGY

900 BROAD STREET, NEWARK 2, N. J. **Telephone: MItchell 2-3420**

Director, CRAIG R. GARTH, Captain, U.S. Navy (Ret.)
Approved by the New Jersey State Department of Education

We Answer Doctors' Telephones

— OUR TWENTY - EIGHTH YEAR —

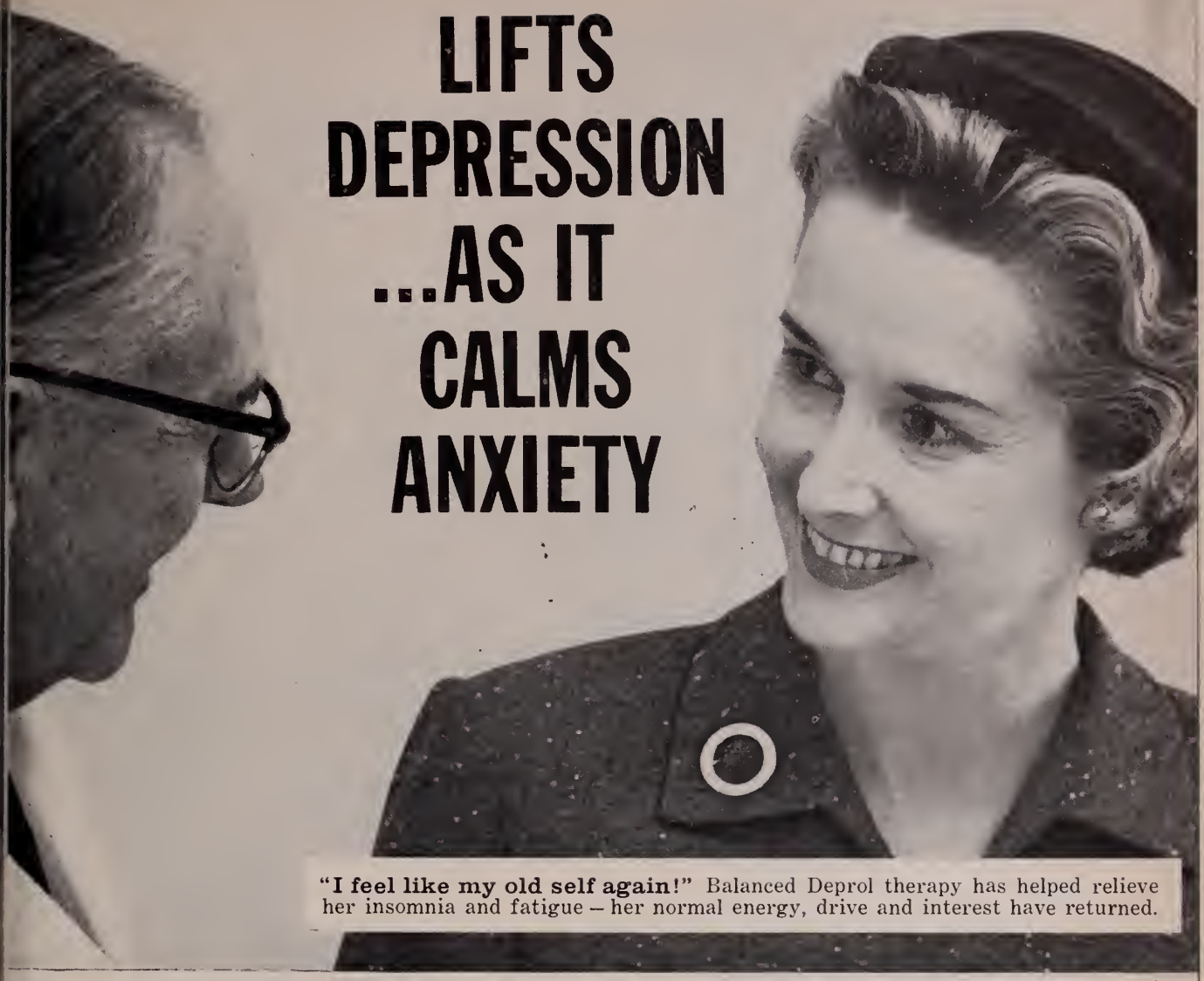
TELEPHONE SECRETARIAL SERVICE, Inc.

GABRIEL A. BELLIN, President

NEWARK - ELIZABETH - FAIR LAWN - PASSAIC - MORRISTOWN

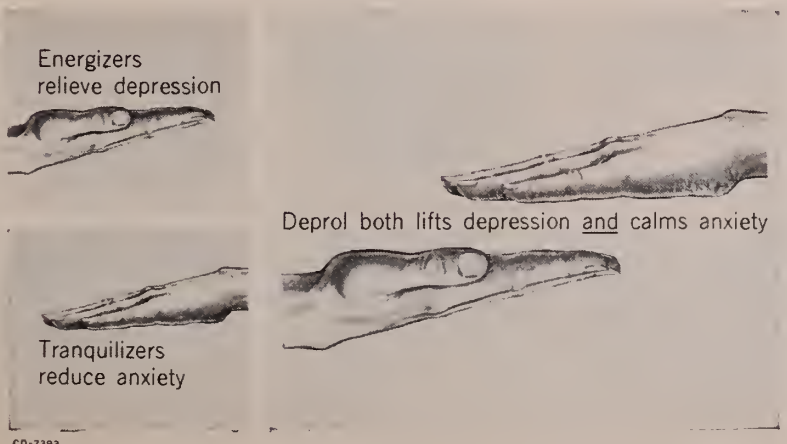
FOR FULL INFORMATION — CALL MARKET 4-0400

LIFTS DEPRESSION ...AS IT CALMS ANXIETY



"I feel like my old self again!" Balanced Deprol therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

Brightens mood...relaxes tension



Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be increased gradually up to 3 tablets q.i.d. With establishment of relief, the dose may be reduced gradually to maintenance levels.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrachloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets.

Write for literature and samples.

▲Deprol®

WALLACE LABORATORIES
Cranbury, N.J.

CD-7393



Expert diagnosis...

makes golf interesting on our 18-hole championship course. You'll also enjoy swimming, riding, hiking, or just plain loafing.

Now enjoy the spacious, luxurious, NEW ASSEMBLY HALL along with our other well appointed meeting rooms.

For information or reservations, call: Pocono Manor, Pa., Area Code 717-839-7111.

POCONO MANOR INN
Pocono Manor, Pa.

Host To All-Star Golf

CONTRACT AEROSOL and LIQUID FILLING

Pressure and Cold Fill. Enclosed Filling Area for Pharmaceutical Aerosols. Modern Research and Control Laboratories. Ample Storage and Shipping Facilities.

Write or Telephone:

FLUID CHEMICAL COMPANY, INC.
862 Mt. Prospect Avenue
Newark, New Jersey

Telephone—
New Jersey: HUmboldt 4-1000
New York: WHitehall 3-0540

GREETINGS FROM

COLFAX
LABORATORIES

A DIVISION OF SHULTON
CLIFTON, NEW JERSEY • TORONTO

MAKERS OF



FOR PROBLEM SKIN

advancing or complicated hypertension responds to

new Naquival®

brand of trichlormethiazide and reserpine

with STEP-BY-STEP reduction (no sudden drops[1-4]) of elevated blood pressure ☐ relief of associated headache,[3,4] dizziness,[2-4] edema,[2-5] anxiety and tension[1] ☐ simplified dosage (twice daily)...long-term economy

(With new NAQUIVAL there are no reported toxic effects,[2-5] side effects are minor and infrequent,[1-5] and salt restriction[1,5] or added potassium[1] is rarely needed.)

Supplied: NAQUIVAL Tablets, containing 4 mg. trichlormethiazide and 0.1 mg. reserpine, bottles of 100.

References: (1) Ernst, E. M.: Current Therap. Res. **3**:167, 1961. (2) Starling, R. J.: J.M.A. Georgia **50**:442, 1961. (3) Sprogis, G. R.: Current Therap. Res. **3**:393, 1961. (4) Coffee, H. L.: Clin. Med. **69**:1561, 1962. (5) Mattey, W. E.: Indust. Med. **31**:33, 1962.

Schering

mild or moderate hypertension responds to

Naqua®

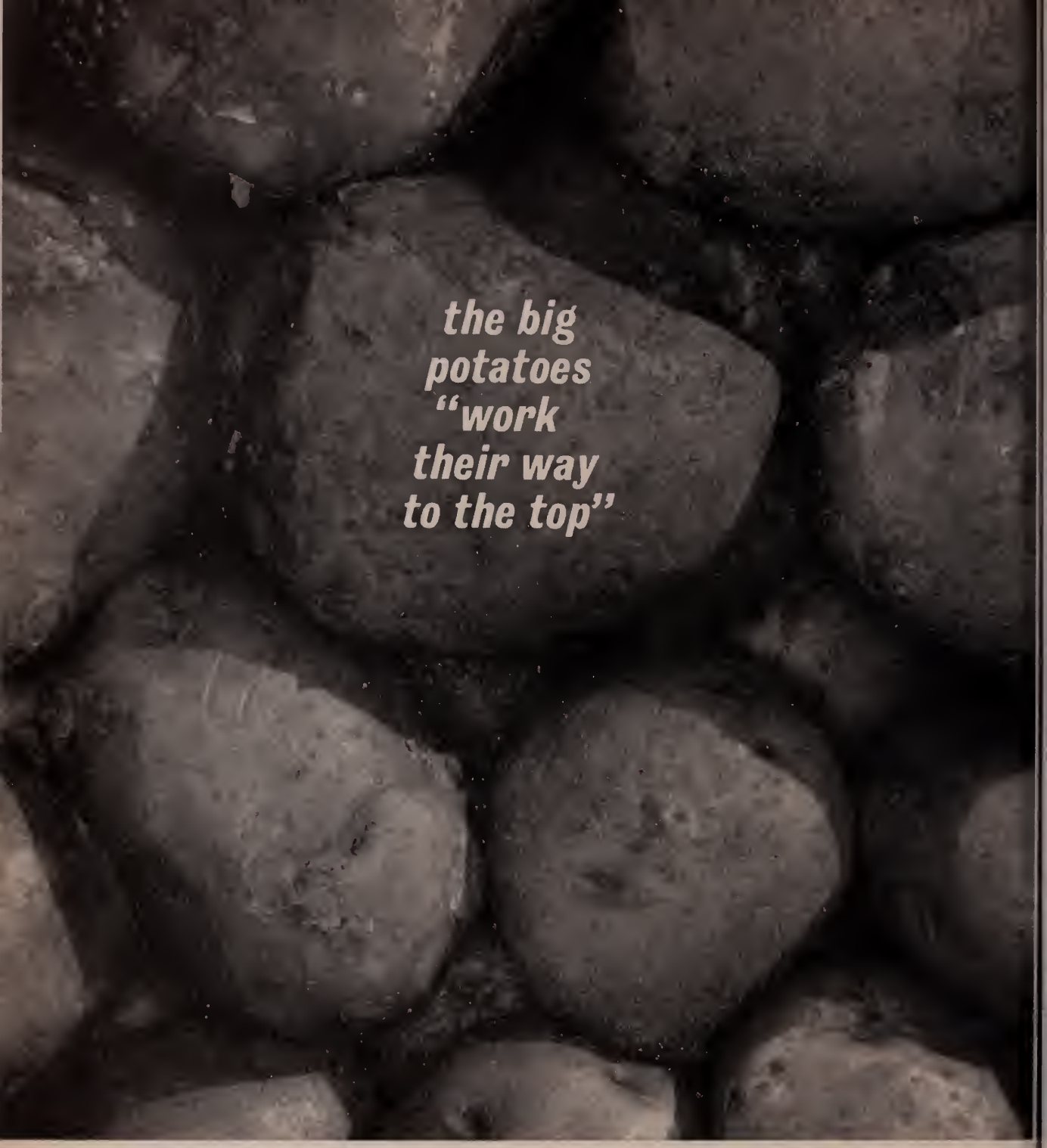
brand of trichlormethiazide

Reduces elevated blood pressure while providing symptomatic relief...permits more normal activities...liberalizes salt intake...in severe hypertension, potentiates other antihypertensives...as a diuretic, controls edema with minimal, once-daily dosage.

Supplied: NAQUA Tablets, 2 and 4 mg., scored, bottles of 100 and 1000.

For complete details concerning NAQUIVAL and NAQUA, consult Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Bloomfield, N. J.

S-160



Jostle a peck of potatoes long enough and the little ones will fall to the bottom; the big ones work their way to the top. So do the larger particles of an admixture of powdered chemicals. Unless steps are taken to keep particle sizes uniform, the active ingredients will not be evenly dispersed throughout an excipient. That is why Lilly pharmaceutical chemists establish precise specifications; maintain rigid controls. A few more steps are added and the cost is slightly increased, but priceless uniformity is assured in the finished product.

Eli Lilly and Company • *Indianapolis 6, Indiana, U.S.A.* Lilly

390074

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

On the Boardwalk in Atlantic City

From the four corners of the nation, doctors will pour into Atlantic City this June for the AMA convention. We New Jersey physicians have a double chance at this traditional combination of serious study and pleasant relaxation. We can come in May and again in June. Our own annual meeting will be held as usual in the playground of the world.

It opens on Saturday, May 11, with the meeting of the House of Delegates. Even those who are not delegates or alternates are welcome to come in and see this parliament of New Jersey medicine in operation. The scientific program starts on Monday and there is something here for everybody, from the most versatile general practitioner to the most sharply specialized consultant.

In a state the size of Texas or Alaska there may be an excuse for not getting to a society convention, since the meeting might be 500 miles away. But in a nice little compact state like ours, there can be no excuse for not coming to a session in our own backyard.

Physicians' Responsibilities in Child Abuse

In 1961, a small group of hospitals (only 75 of them) reported 302 cases of gross physical abuse of children.* More than 10 per cent of these innocent victims died. Another report* indicates that about 33 per cent of abused or battered children are seen by physicians

Published Monthly Since 1904
Under the Direction of the Committee on Publication
Frank L. Rosen, M.D., Chairman

Henry A. Davidson, M.D., Editor
Theresa E. Goeke, Assistant Editor

Place of Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — EXport 4-3154
Each member of the Society is entitled to receive a copy of The Journal every month

Whole Number of Issues 704

Vol. 60, No. 4 APRIL, 1963 30 Cents - $3.00 per year

soon after being injured; but that fewer than 10 per cent of cases referred to agencies are reported by physicians. Reluctance to notify about such cases is due to anxiety about possible reprisal by parents, unwillingness to take time to go to court, fear of being sued for libel, false arrest or defamation; and, let it be noted, by a naive unwillingness to assume that any adult would viciously or severely beat a child. Actually, the doctor ought to suspect abuse whenever a child shows purpuric lesions, multiple fractures in differing stages of healing, or subdural hemorrhage.

Study of a large series of cases fails to produce a consistent pattern, although certain factors do stand out. Most of the abuse was by parents—equally divided between fathers and mothers.* Most of the families had lived for many years in the same neighborhood. Most of the assaulting parents were young. Half were involved in marital discord; but significant financial difficulties were found in only one case in five. As might be expected, the abusing parent was an essentially angry person—angry at the world, but taking it out on (usually) one of a fairly large brood of children. Many of the mothers were fanatically clean.* Physical abuse was less common in a slovenly household than in a meticulously clean one. Most of the abusing parents had had no previous trouble with the law. More than 70 per cent of the little victims* were under the age of 13. Usually the parents (commonly the mother) vigorously defended the abuse on the grounds that this was the only language the child could understand; or (usually said by the father) that "chastisement" was a proper parental duty.

The U.S. Children's Bureau suggests that physicians should be legally required to report any injuries found on children. Few states impose any such duty, but if doctors are reluctant to report such findings voluntarily, there may be mounting pressure to make it compulsory.

It should seem unnecessary to urge any physician to take seriously his civic responsibility in this area. It is, more likely, a matter of being sensitive to the possibility. Here is an area where the stereotyped cliché, "high index of suspicion" would seem most appropriate.

*These citations are from the brochure *Protecting the Battered Child*, issued in 1962 by the American Humane Association, Box 1266, Denver, Colorado.

Our New Dress

With this new issue, THE JOURNAL comes to you in a more modern dress. The old buff cover has been with us since the turn of the century. Remaining unchanged over the years it has become a familiar kind of trademark. During these past several decades, most medical journals have adopted more modern type design and cover layouts. Some, indeed, take the position that a change every once in a while is healthy; that it stimulates reader interest and awareness in the journal.

The Trustees and the Publication Committee have finally decided on this new cover. We hope you will like it. In any event, this is an external change only. The spirit remains unaltered and THE JOURNAL will continue to serve you as a combination postgraduate course, news medium, house organ, and binding tie among our statewide membership.

Psychosomatic Profile • • •

Somatopsychic and Psychosomatic Relationship in Epilepsy

The Jacksonian concept of an epileptic seizure as a clinical correlate of an excessive neuronal discharge has been widely accepted. If the focus of the discharge is in the temporal lobe, the resulting seizure may be manifested by purely psychic events such as short episodes of anxiety and depression.[1] A discharging focus in the posterior temporal cortex may induce visual hallucinations. However, the *content* of the hallucinatory phenomenon will be dependent on the emotional experiences of the patient. Uncontrollable multiple seizures, particularly in childhood, may produce intellectual and emotional deterioration.[2] Penfield[3] suggests that not all the brains are equally susceptible to damage and whereas one brain will suffer through a single seizure, another will withstand a number of attacks. This is why epileptologists and pediatricians disagree on prescribing preventive anticonvulsive medication to children subject to febrile seizures. Is there an inverse relationship? Do emotions have an effect on seizures? Bleuler[4] and Clark[5] believed that idiopathic epileptics have idiomatic personality traits. Lennox[6] and many modern students of the problem deny such a relationship and comment on the rich variety of personalities among epileptics. Lennox[6] agrees that emotions may precipitate seizures "as a gun may be fired by a very slight pressure of the trigger." The psychoanalytic writers believe that a seizure is a purposeful though unconscious activity aimed at solution of repressed conflicts, particularly conflicts connected with rage, sex and a need to return to the intrauterine, fetal existence. Barker[7] believes that petit mal attacks occur when unconscious emotions endanger the patients' acceptable pattern of behavior.

Negative emotional states may increase the number of seizures in epileptics. I accept Lennox's "trigger" theory. The psychoanalytic explanation of seizures (as a solution of repressed conflicts) is scientifically untenable. Since emotions may trigger seizures, mere prescription of anticonvulsive medication is insufficient in the treatment of epileptics. Evaluation of patient's emotional state, plus guidance, reassurance, explanation of the illness and its treatment, as well as avoidance of unnecessary restrictions which destroy self-confidence and self-respect are the basic prerequisites for good handing of a seizure problem.

—EUGENE REVITCH, M.D.

1. Weil, A.: Am. Journal Psychiatry, 113:140 (Aug. 1956).
2. Zimmerman, A. *et al.*: Arch. Neurol. and Psychiat., 65:545 (May 1951).
3. Penfield, W. and Jasper, H.: Epilepsy and the Human Brain, Boston (1954) Little Brown.
4. Bleuler, E.: Textbook of Psychiatry (translated by A. A. Brill) New York (1930) Macmillan.
5. Clark, L. P.: Proc. Ass'n. Res. Nerv. Ment. Dis., 7:65 (1931)
6. Lennox, W. G.: Seizure States, Chapter 31 in Hunt, J., Personality and the Behavior Disorders. Ronald Press, New York (1944).
7. Barker, W.: Psychosomatic Medicine, 10:731 (March 1948).

Blood Alcohol Levels

Under present laws coordinated by the National Safety Council, a level of 0.15 per cent of alcohol by weight in the blood constitutes *prima facie* evidence of intoxication. A comparative level has been used for breath; intoxication is presumed at a urine level of 0.20 per cent by weight. "The average 150-pound individual who consumes 4 ounce-and-a-half jiggers of 100-proof whiskey, or 4 bottles of beer on an empty stomach, will within approximately ½ to ¾ of an hour reach a blood alcohol or urine alcohol of this level."

Medical Annals of the District of Columbia, September, 1959.

Announcements • • •

Physician-Clergy Meeting

A unique feature of the June session of the AMA (in Atlantic City, of course) is the June 16 evening session on relations between physicians and clergymen.

Featured speakers will be The Most Rev. Fulton J. Sheen, Catholic Bishop of New York and a TV personality, and Edward R. Rynearson, M.D., of the Mayo Clinic, Rochester, Minn. Dr. Rynearson appeared before the AMA annual meeting last year in Chicago. He questioned the use of extreme measures in prolonging the life of terminal cancer patients.

"The ill person often is more than physically ill," Dr. Rynearson said. "He is—at least to a degree—also mentally, spiritually and socially ill at the same time. All of these aspects must be considered in treatment.

"Often the physician and the clergyman can help each other in dealing with the patient or his family in cases of serious illness," Dr. Rynearson said.

The Rev. Dr. Paul B. McCleave, Chicago, director of the AMA's Department of Medicine and Religion, said the program is the result of a reciprocal exchange of information between medicine and the clergy at the local medical society level throughout the country.

Symposium on Anxiety

The Academy of Psychosomatic Medicine will hold a symposium on "Anxiety and Depression" at the Marlborough Blenheim, Atlantic City, on June 15 and 16, 1963. The sessions begin at 8:30 a.m. on Saturday, June 15.

For further details, write to Wilfred Dorfman, M.D., 1921 Newkirk Avenue, Brooklyn 26, N. Y.

Premarital Blood Specimens

After June 30, 1963, the State Department of Health Laboratories will discontinue blood grouping and typing of premarital blood specimens. Until recently, funds from the State Civil Defense Program were available to support this project. A change in policy and emphasis by Civil Defense has resulted in a withdrawal of support for continuance after July 1, 1963. However, there are ample local facilities in over 100 approved laboratories to serve the needs of physicians for these tests, if required.

The law still requires that premarital blood specimens be submitted to the State Laboratory or State-approved laboratories for the tests for syphilis as heretofore.

Rheumatism Association Meets in N. J.

The American Rheumatism Association will meet in Atlantic City June 13 and 14. For complete program, write to the Association at 10 Columbus Circle, New York 19, N. Y.

Trauma and Personality

The effects of injury on personality will be thoroughly explored at a two-day colloquium in New York City this October. This seminar is under the auspices of the Psychiatric Research Association. For detailed program, write to Dr. David Impastato at 40 Fifth Avenue, New York 11, N. Y.

Financial Aid for New Jersey Amputees

A New Jersey upper extremity amputee is offered financial aid through the New Jersey State Federation of Women's Clubs. Assistance is available to any resident meeting requirements set up by the organization. This Upper Extremity Amputee Fund, established by the state-wide organization of 4500 young women in 1955, has already given assistance to 80 residents.

Applications for assistance and further information is available from:

Junior Membership Department, Room 1009
Federation of Women's Clubs
605 Broad Street, Newark 2, New Jersey

Book Reviews

Current Gastroenterology. Edited by Gordon McHardy, M.D. New York, 1961. Harpers. Pp. 674. ($16.50)

Seventy-four authorities here present a comprehensive review of clinical, roentgen, and laboratory aspects of functional and organic affections of the digestive tract, including liver, gallbladder, and pancreas.

The roentgenologist and laboratorian will find an extensive preview of procedures now within the realm of research, which will probably become practical diagnostic tools in the near future. Thus, the image amplifier and fluorocinematiography may replace our present fluoroscopic examination.

Added to the older laboratory technics are: paper electrophoresis of gastric juice, glucuronide blood level, radioisotope and serotonin determinations in the diagnosis of protein-losing gastro-enteropathies, liver disease, malabsorption syndromes, and carcinoid, respectively.

The practicing clinician will enjoy the panel discussions on peptic ulcer, liver and pancreas. Here old and the new therapeutic views are contrasted with the vigor and pyrotechnics reminiscent of the annual gastroenterologic conventions.

Marshak's chapter on roentgen lesions of the small bowel must be singled out as a classic work replete with superb radiographic illustrations, accompanied by excellent clinical notes.

This book will be a constant source of reference, not only to the practicing gastroenterologist, but also to teachers and those charged with the duty of organizing departments of gastroenterology in hospitals.

This reviewer was pleasantly surprised to find one of his own radiographs in the chapter on postcholecystectomy syndrome.

I. Gelber, M.D.

Clinical Pathology. Benjamin B. Wells, M.D., Ph.D. Philadelphia, 1962. Saunders. Ed. 3. Pp. 541, illustrated. ($9.00)

This book is "offered to medical students and physicians as a guide in the application and interpretation of clinical laboratory studies." The chapters are arranged by organ system, *e.g.*, gastrointestinal, respiratory, cardiovascular, and so on. In addition, there are chapters oriented towards specific clinical situations, *e.g.*, obstetrics, surgery, and infectious diseases. Each chapter covers laboratory tests appropriate for the diagnosis of diseases of that system with a discussion of the interpretation, advantages and limitations and the role of the test in differential diagnosis This unique arrangement is appealing because it corresponds most closely to the way in which the physician encounters the patient's problem. There is a brief final chapter describing some of the superficial procedures for analysis of urine, feces, and blood cell counting.

To a pathologist it is apparent that one of the most difficult problems facing the clinician is choosing economically the most helpful tests and in the interpretation of test results. The book is ideally arranged to help the clinician make such a selection. Dr. Wells' opinions are sound and consonant with good medical practice. The tests included are comprehensive and modern. The interpretation and limitations of the tests are well summarized. There are only a few areas where additional discussion and emphasis could well be included. For example, the thromboplastin generation test has become increasingly well known, practical and available to the clinician but receives only scant mention. Additional information on the use of radioisotopes in some areas (an important part of laboratory diagnosis), particularly for thyroid scanning, could be included. The most noteworthy omission is the author's failure to mention vaginal exfoliative cytology as a routine procedure for the diagnosis of uterine cancer as well as trichomoniasis and for estimation of homone levels.

However, these few shortcomings do not detract from the considerable overall usefulness of this book for the beginner as well as for the sophisticated diagnostician.

Jacques B. Wallach, M.D.

Modern Concepts of Hospital Administration. Edited by Joseph K. Owen, Ph.D. Philadelphia, 1962. Saunders. Pp. 823, with 125 illustrations. ($16.00)

During the last 25 years, hospital administration has developed as a new profession. At one time it was seen as a simple operation—a physician as chairman of a medical staff and a layman acting as a sort of innkeeper for patients. Today, however, hospital management has become as fearfully complex a business as the hospital itself. The administrator now is a fund-raiser, an architect, an engineer, a personnel expert, a business man, a public relations man, and a housekeeper.

The present book is a one-volume library of hospital administration. It includes 51 chapters and six appendices. The text includes such material as getting along with trustees, providing training and research facilities, legal problems of hospital administration, estimating needs for parking space, financing of hospital care, relations with government, home care, convalescent units, social service, central supply operations, dietary services, anesthesia, medical record libraries, drug rooms, hospital architecture, and so on. Each chapter is written by an expert.

With so varied a menu, it is impossible to pick out any one course as more necessary than another. Certainly there will be some dish here to everyone's taste. The volume is ambitious; and while many chapters are water-logged by pious generalities, long-winded introductions, and solemn repetitions of the obvious, there is a lot of meat here—and it's worth cutting through the fat to get at it. Almost every chapter is solid; and whoever has responsibility for hospital management can profit by keeping this volume in his bookcase and dipping into it frequently.

HENRY A. DAVIDSON, M.D.

Gynecologic Endocrinology. By Edward A. Graber, M.D. Philadelphia, 1961. J. B. Lippincott Company. Pp. 218. ($7.50)

Unlike the typical endocrinology textbook (which weighs anything from five to ten pounds) with an opening chapter which overawes the general reader with obstruse chemical formulae, this little volume gets down to business at once. A ready reference manual for the busy practitioner, it tells what, why, where, and what to do about it.

Written in outline form, each heading begins with a definition. It then lists symptoms and helpful laboratory tests with their normal values. This is followed by a discussion of treatment. Proprietary names are offered and dosage suggested.

Sections deal with each of the endocrine glands, and with menopause, pregnancy, abnormal menstrual function, embryologic and developmental abnormalities. There is a section of miscellaneous topics such as, hirsutism, mastodynia, endocrine treatment of gynecologic malignancies and so forth.

The last chapter enumerates the commonly used commercial preparations and explains equivalent dosages. On the inside back cover is a table of normal hormonal values in the adult female.

The format of the manual makes for easy reading, since the outline style eliminates redundancy.

This admirable book is a valuable tool for desk reference for the gynecologist, obstetrician or general practitioner.

ZELDA I. MARKS, M.D.

Laboratory Medicine: Hematology. By John B. Miale, M.D. St. Louis, 1962. Mosby. Ed. 2. Pp. 918 with 320 illustrations. ($17.00)

In its second edition Dr. Miale's well-known book has been enlarged and improved. A change of format from single to double column and a slight increase in the size of the page provides space for many additions to the previous edition. Additional charts, diagrams and photographs are to be found in almost every chapter. A thorough job has been done in bringing the material in line with current concepts of hematology. The new information has been smoothly incorporated into the text and makes for ease of comprehension.

Of particular interest are the sections dealing with erythropoesis and the role of Vitamin B-12 in that process. Hemoglobin and new information about the hemoglobinopathies are comprehensively covered; factors affecting red blood cell survival, the anemias and laboratory methods of study also receive full attention. Discussions of the myeloproliferative disorders, the leukemias and lymphomas also have been expanded, and the chapter on hemostasis and blood coagulation incorporates discussions of theories not present in the previous edition.

The appendix remains a reliable reference for laboratory methods and several new technics have been added. The book is, as the title states, "Laboratory Medicine." Problems of therapy or clinical management receive no attention. This volume is a stout piece of work and will be a reliable addition to any medical library, whether for student, clinician or pathologist.

ALLAN S. ELLIS, M.D.

Beyond Telepathy. Andrija Puharich, M.D. New York, 1962. Doubleday. Pp. 312. ($4.50)

Physicians, being "natural scientists," are reluctant to become involved in telepathy, clairvoyance, Yogi, psychokinesis, and table rapping. We have tried so hard and so long to counteract the mystical, magical and supernatural aspects of medicine that we seem afraid to make any concessions in this area. As a result, most MD's won't even look at the evidence which supports such psi phenomena. It is as if by closing our eyes and saying "psi, psi, go away," it will all vanish.

Dr. Puharich, a neurophysiologist and internist, here makes a serious attempt to explain telepathy and other parapsychologic phenomena in physiologic terms. How he succeeds will be up to each reader to determine for himself. There is no appeal to faith here, and no wallowing in mysticism. Indeed, some of the electronic physics and higher mathematics involved may be beyond many of us. If half of what Dr. Puharich says is verified, we may be opening the door into a world besides which outer space seems small indeed.

VICTOR HUBERMAN, M.D.

Tomorrow's Miracle. By Frank G. Slaughter. New York, 1962. Doubleday. Pp. 306. ($3.95)

Benson Ware—physician, missionary, one-time faith-healer—would never forget the squalid surroundings of his youth. Because he believed his escape from them an act of mercy, the path of selflessness he chose led him to rise above the vain ambitions of fame and fortune to the realization of his desire for a life of sacrifice in the medical missionary field.

This novel—the author's 34th—outrages credibility. The hero is too good to be true. He out-Dooley's Doctor Tom, who had a superior, simple and single objective toward which he moved. Doctor Ware rides off in all directions. Temptations to which he is subjected are more than any mortal could be expected to withstand. Our hero proves he is less than mortal. He jousts with sex—and loses on occasion.

The reader feels the heat and steam and the green poison of the jungle, which he is expected to do. But the blood and sweat and tears of medicine form an ocean of mediocrity which no man should be expected to swim.

THERESA E. GOBKE

Postpartum Psychiatric Problems. J. A. Hamilton, M.D., Ph.D. St. Louis, 1962. Mosby. Pp. 156. ($6.85)

Pregnancy is frequently the precursor of intense emotional distress. Commonly this subsides, and the individual adjusts to the situation. One anticipates that the delivery of the infant will bring about a return to normal maternal attitudes. This book describes the psychiatric problems which may arise in greater or lesser degree during the postpartum course. Careful attention to detail during the postpartum course will elicit many of the responses which alert one to the existence of emotional stress. The symptoms are well enumerated here. Insomnia, restlessness, and anorexia are given proper prominence as symptoms suggesting that all is not well. This author is the first I have read who describes, and offers some physiologic explanation for, the "third day weeps."

Extensive discourse upon the history, physiology, and endocrinology of postpartum psychosis is presented. Rigorous attempts at classification are avoided. Delirium, mania, and the dissociative syndromes are succintly portrayed. The role of anxiety postpartum is stressed and the endocrine relationships involving the thyroid, pituitary, and adrenal cortex are included. Dr. Hamilton has had wonderful success in the treatment of postpartum depression and lethargy with tri-iodothyronine. I do not know whether this success has been universal, but thyroid extract is a considerable aid in the management of many of the postpartum signs and symptoms. Ignorance of the subject forbids my discussing the psychiatric therapy described.

This book is well set up. The type is large and the spacing adequate for easy reading. The manner of writing is such that the book may be read as entertaining literature. The author's style is delightful; he does not attempt to overwhelm you so that you are convinced of his erudition. I like the book and have learned from it.

WILLIAM F. THORNLEY, M.D.

Textbook of Endocrinology. Edited by Robert H. Williams, M.D. With contributions by 21 authorities. Philadelphia, 1962. Saunders. Third Ed. Pp. 1204, illus. ($21.00)

This third edition of an excellent textbook, now rewritten with a wealth of new material, emerges as an outstanding volume. A chapter on general physiology of the endocrines is followed by separate sections on each of the endocrine glands. The pituitary (two chapters—one on adenohypophesis and one on neurohypophesis), thyroid, ovary, testis, adrenal, parathyroids, pancreas, and a short dissertation on the pineal gland, follows.

There is an excellent chapter on lipid metabolism and the lipopathies. The effects of hormones on protein metabolism, on water and electrolyte balance, influence on growth and development, hypoglycemia and hypoglycemosis, are all treated separately, as are disorders of sexual differentiation, genetics and endocrinology, and neuroendocrinology. Also included is a discussion of hormones and cancer. The book ends with a chapter on laboratory procedures with complete details, and a last word resumé on diagnosis and treatment, with commentary on the commercially available hormone preparations.

Each chapter stands by itself as a complete discussion not only of the endocrine factors but of the interrelated medical aspects. The book is usefully illustrated with graphs, charts and pictures, and the subheadings of the chapters make reference easy.

While it will probably be used as a teaching text in medical schools, the book is indispensable for the endocrinologist and the internist. The general practitioner will find it an invaluable addition to his medical library; and as a reference book, the pediatrician and the neurologist will find guidance.

For this kind of text with reference volume, it is remarkably easy to read, though like all books of this sort, it must be taken in small doses; it is highly concentrated and needs time to digest.

ZELDA I. MARKS, M.D.

The 197th Annual Meeting
of
The Medical Society of New Jersey

Saturday-Wednesday, May 11 - 15, 1963

HADDON HALL, ATLANTIC CITY

Daily Schedule

Friday, May 10, 1963

5:00 p.m.—Board of Trustees

Saturday, May 11, 1963

10:00 a.m.—Registration Opens
10:30 a.m.—New Jersey Trauma Committee
2:00 p.m.—House of Delegates
3:30 p.m.—Golden Merit Award Ceremony
4:00 p.m.—Open Discussion on Medical-Surgical Plan
6:00 p.m.—Board of Trustees' Dinner (by invitation only)
8:30 p.m.—Nominating Committee

Sunday, May 12, 1963

11:00 a.m.—Reference Committees
2:00 p.m.—House of Delegates (election)
4:30 p.m.—New Jersey Society of Internal Medicine
5:30 p.m.—Reception Honoring President-Elect Kaufman

Monday, May 13, 1963

9:00 a.m.—Exhibits Open
9:30 a.m.—Scientific Sessions:
Medicine, Metabolism, Psychiatry and Neurology
Anesthesiology, Cardiovascular Diseases, Obstetrics and Gynecology
Rheumatism
9:45 a.m.—Motion Picture Theatre
2:00 p.m.—Scientific Sessions:
Pediatrics, Surgery
Dermatology
Allergy, Chest Diseases, Radiology
2:00 p.m.—Motion Picture Theatre
4:30 p.m.—Radiological Society of New Jersey
5:00 p.m.—Organization Meeting of School Physicians
7:00 p.m.—Dinner-Dance

Tuesday, May 14, 1963

9:00 a.m.—House of Delegates
9:30 a.m.—Special Scientific Session
9:45 a.m.—Motion Picture Theatre
1:30 p.m.—House of Delegates Reconvenes
2:00 p.m.—Special Scientific Session
2:00 p.m.—Motion Picture Theatre
6:00 p.m.—Technical Exhibitors' Reception-Buffet
9:00 p.m.—Dance

Wednesday, May 15, 1963

9:00 a.m.—Board of Trustees
9:30 a.m.—Scientific Sessions:
Clinical Pathology, Gastroenterology and Proctology, General Practice
Ophthalmology
Otolaryngology
Orthopedic Surgery, Urology
9:45 a.m.—Motion Picture Theatre
1:00 p.m.—Luncheon and Meeting, New Jersey Academy of Ophthalmology and Otolaryngology
1:00 p.m.—Luncheon, New Jersey Branch of American Medical Women's Association
1:00 p.m.—Exhibits and Registration Close

Dinner-Dance

Monday Evening, May 13, 1962

7:00 p.m.

Honoring

PRESIDENT AND MRS. LOUIS S. WEGRYN

Welcome

Mrs. John J. Torppey, President, Woman's Auxiliary

Introductions

Mrs. Walter S. Booth, President-Elect, Woman's Auxiliary

Jerome G. Kaufman, M.D., President-Elect

Official Guests

Presentations

Fellow's Key

To: Louis S. Wegryn, M.D., President

By: Ralph M. L. Buchanan, M.D., Immediate Past-President

Fellowette's Pin

To: Mrs. John J. Torppey, President, Woman's Auxiliary

By: Louis S. Wegryn, M.D., President

Entertainment

Dancing

House of Delegates

President, Louis S. Wegryn, M.D., Elizabeth
Secretary, Marcus H. Greifinger, M.D., Newark
Parliamentarian, Robert M. Backes, Trenton

Sessions

Saturday Afternoon, May 11, 1963

2:00 p.m.—First Session:

Call to Order
Invocation
Organization of the House
Transactions of 1962 Annual Meeting
Introduction of Guests and Delegates from Other States
Annual and Supplemental Reports
Resolutions
Proposed Amendments to the Constitution and Bylaws
New Business
Announcements

Sunday Afternoon, May 12, 1963

2:00 p.m.—Second Session:

Report of Nominating Committee
Election

Tuesday Morning, May 14, 1963

9:00 a.m.—Third Session:

Reports of Reference Committees

11:30 a.m.—Luncheon Recess

1:30 p.m.—Session Continued:

Reports of Reference Committees
Unfinished Business
Installation of Incoming President
Inaugural Address
Adjournment

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

Reference Committees

Sunday, May 12, 1963

11:00 a.m.

Reference Committee on Constitution and Bylaws

Report of the:

- Committee on Revision of Constitution and Bylaws

Amendments to Constitution

Amendments to Bylaws

Reference Committee "A"

Reports of the:

- President
- Board of Trustees
- Secretary
- Judicial Council
- Committee on Credentials
- Executive Director

Reference Committee "B"

Reports of the:

- Treasurer
- Committee on Finance and Budget
- Committee on Publication
- Committee on Medical Student Loan Fund

Reference Committee "C"

Reports of the:

- Medical Service Administration
- Medical-Surgical Plan
- Medicare Program

Reference Committee "D"

Reports of the:

- Committee on Medical Defense and Insurance
- Committee on Medical Education
- Committee on Physicians Placement Service
- Committee on Retirement Plan for Physicians

Reference Committee "E"

Reports of the:

- Council on Legislation
- Council on Public Relations

Reference Committee "F"

Reports of the:

- Council on Medical Services, and its
- Special Committees on:
  - Occupational Health
  - Workmen's Compensation

Reference Committee "G"

Reports of the:

- Council on Public Health, and its
- Special Committees on:
  - Cancer Control
  - Child Health
  - Chronically Ill and the Aging
  - Conservation of Hearing and Speech
  - Conservation of Vision
  - Maternal and Infant Welfare
  - Mental Health
  - Rehabilitation

Reference Committee "H"

Reports of the:

- Committee on Annual Meeting, and its
- Subcommittees on:
  - Scientific Exhibits
  - Scientific Program
- Committee on Honorary Membership
- Committee on Disaster Medical Care
- Committee on Nursing Education
- Committee on Traffic Safety
- Advisory Committee to the Woman's Auxiliary

Nominations for Emeritus Membership

Motion Picture Theatre

Monday and Tuesday, May 13 and 14, 1963

9:45 a.m.

Broken Glass

Produced for the University of California Institute of Transportation and Traffic Engineering

Shows the necessity of seat belts, increasing one's safety while driving. Actual crash scenes are shown in which the results of crashes without seat belts are compared with crashes where belts were used. Sealt belts assure less likelihood of injury to the wearer.

10:05 a.m.

Frontiers of Allergy

Leo H. Criep, M.D., Pittsburgh, Pa.

Affords a visual presentation of the over-all subject of allergy from its basic mechanisms to methods of treatment. Animation shows the types of antigens originating from outside the body and haptenes which form antigenic complexes with proteins already present in the body. The formation of a specific antibody in response to stimulation by the antigen is also visually presented. Various tests used in detecting antibodies are shown, and laboratory scenes of several experiments demonstrate allergy in the living animal and in isolated tissue from such an animal. Anaphylactic reactions and "serum sickness" are discussed. Various tests used in allergy diagnosis are discussed and illustrated.

10:40 a.m.

Life in Your Hands

Sponsored by SK&F as a Public Service

Illustrates how heart-lung resuscitation, together with direct breathing, can maintain circulation of air and blood following a heart attack.

10:55 a.m.

Cancer Detection—Proctosigmoidoscopy in Office Practice

Produced in cooperation with The Strang Cancer Prevention Clinic, Department of Preventive Medicine; and The Rectal-Colon Service, Department of Surgery, Memorial Hospital for Cancer and Allied Diseases, New York, N. Y.

Illustrates the necessary equipment for routine proctosigmoidoscopy, home and office preparation of the patient for this procedure; and the examination itself, which includes inspection, palpation and proctosigmoidoscopy. By use of a special endoscopic camera, the film also depicts the mucosal areas of the sigmoid colon, showing actual pedunculated and nonpedunculated polyps. The film concludes with a diagnostic follow-up with barium enema. According to Dr. Day, this simple and safe examination can be performed by GP's as part of their routine office procedure.

11:15 a.m.

Management of Hypertension

Produced for the American College of Physicians

A discussion of the treatment of hypertension by eminent authorities in the field, with special reference to the use of methonium compounds; reserpine, veratrum and hydralazine; different types of hypotensive drugs in combination; and specialized treatment for each of the various phases of essential hypertension.

2:00 p.m.

Play and Personality

Filmed at the Cassel Hospital in Surrey, England

The film follows two little boys over a six-month period—one is a crier and the other withdrawn.

2:25 p.m.

Diagnosis of Common Congenital Heart Defects

J. M. Martt, M.D., Columbia, Mo.

A brief introduction is devoted to the general approach to the diagnosis of congenital heart defects with suitable stress being given to the history, physical examination, roentgenography, electrocardiogram, and cardiac catheterization. The remainder of the movie deals successively with the clinical and laboratory features of the more common heart anomalies. Atrial septal defects, ventricular septal defect, patent ductus arteriosus, coarctation of the aorta, pulmonic stenosis, tetralogy of Fallot and transposition of the great vessels.

2:55 p.m.

Cystic Fibrosis

National Cystic Fibrosis Research Foundation

This film was prepared to bring the disease called Cystic Fibrosis to the attention of those who might encounter it, to aid them in making a correct diagnosis and to instruct them in the techniques currently being used to prolong life.

3:35 p.m.

An Otological Seminar

Medical Film Guild

Shows the physical aspects of a number of ear diseases. Explains the concept of impedance and describes ear diseases which are analyzed as mass lesions, stiffness lesions, and friction lesions. Shows serous otitis, glomus tumor of the middle ear, osteogenesis imperfecta, inner ear lesions demonstrating recruitment, and acoustic trauma.

4:15 p.m.

Life in Your Hands

Wednesday Morning, May 15, 1963

9:45 a.m.

Broken Glass

10:05 a.m.

Life in Your Hands

10:20 a.m.

Management of Hypertension

11:25 a.m.

Diagnosis of Common Congenital Heart Defects

11:55 a.m.

Play and Personality

Film program arranged and presented through the cooperation of Smith Kline & French Laboratories, Philadelphia, Pa.

ROOM RESERVATIONS

Complete and mail this form for your room reservation

1963 ANNUAL MEETING—THE MEDICAL SOCIETY OF NEW JERSEY

May 11-15, 1963

Reservation Desk, Chalfonte-Haddon Hall, Atlantic City, New Jersey

Please reserve the following accommodations on the European Plan ( ) American Plan ( )

No. of Rooms	ROOMS WITH BATH		HADDON HALL (Meeting Hdqts.)			CHALFONTE (Across Street)		
	Single	For One Person	$ 9.00 ( )	$10.00 ( )	$12.00 ( )	$ 8.00 ( )	$ 9.00 ( )	$11.00 ( )
	Double (Twin Beds) without ocean view	For Two Persons	$14.00 ( )	$16.00 ( )	$17.00 ( )	$11.00 ( )	$13.00 ( )	
	Double (Twin Beds) side ocean view	For Two Persons	$19.00 ( )	$21.00 ( )	$23.00 ( )	$16.00 ( )	$19.00 ( )	
	Double (Twin Beds) ocean front	For Two Persons	$27.00 ( )	$30.00 ( )		$19.00 ( )	$21.00 ( )	$23.00 ( )
	Double Room and Parlor ocean front		$57.00 ( )					
	Double Room and Parlor side ocean view		$42.00 ( )	$44.00 ( )				
	Double Room and Parlor without ocean view		$34.00 ( )					

For American Plan (Meals) Add $8.25 Per Day, Per Person

Each Additional Person in Double Room $4.00 European Plan or $12.25 American Plan

Modified American Plan (Breakfast and Dinner) Add $7.00 per Day, Per Person

I will share a room with _____

Expect to arrive _____ Depart _____

Name _____

Address _____

This reservation will be acknowledged. Please arrange to double up when possible—single rooms are limited.

Scientific Section Meetings

Monday Morning, May 13, 1963

ANESTHESIOLOGY CARDIOVASCULAR DISEASES, OBSTETRICS AND GYNECOLOGY

Joint Session

Anesthesiology

GEORGE E. COVINTREE, M.D., Chairman, Haddonfield
ROBERT A. MURPHY, M.D., Secretary, Mount Holly

Cardiovascular Diseases

HARPER K. HELLEMS, M.D., Chairman, Jersey City
NORMAN REITMAN, M.D., Secretary, New Brunswick

Obstetrics and Gynecology

F. LELAND ROSE, M.D., Chairman, Haddonfield
DANIEL B. ROTH, M.D., Secretary, Teaneck

9:30 a.m.

Election of Officers

9:40 a.m.

The Heart in Pregnancy

James Metclafe, M.D., Associate Professor of Medicine, University of Oregon Medical School, Portland, Ore.

Increasing knowledge of the physiology of pregnancy has led to increasing safety of pregnancy for both mother and child. This is demonstrably true for women with heart disease and their children. More women with heart disease are having more and healthier babies because of the careful application of an individual life plan of medical and surgical care based upon our knowledge of the physiology of pregnancy.

10:05 a.m.

Symposium on the Management of the Pregnant Cardiac

Moderator

Arthur Bernstein, M.D., Maplewood; Attending in Medicine, Newark Beth Israel Hospital

Obstetrician

Eugene J. Slowinski, M.D., Clinical Assistant Professor of Obstetrics and Gynecology, Seton Hall College of Medicine, Jersey City; and Director of Medical Education for Obstetrics and Gynecology, St. Michael's Hospital, Newark

In the care of the pregnant cardiac patient, the Obstetrician is responsible for good preventive medicine, to prevent anemias, hypovitaminoses, infections and other general health hazards. He is often the only physician to have such an opportunity to educate the young female population.

Good prenatal care is most urgent in the pregnant cardiac. A marked restriction in the ordinary burden of the day can be accomplished by eliminating house work, exercise, strenuous hobbies, and sexual intercourse.

Gorenberg of Jersey City, recently deceased, proposed certain standards of prenatal care which I will call Gorenberg's Principles. They include absolute or modified rest, special hospitalization for severe cases or those in failure, weekly visits to the physician, and restriction of cesarean section for obstetrical indications only. In weekly visits to the physician, the internist and the obstetrician must treat the patient TOGETHER not ALTERNATELY. Thus, phone calls or immediate written memos are important to let the other member of the team know what one is doing. This is most important in the use of additional drugs.

At delivery, it is more important to use anesthesia techniques which are familiar to the obstetrician and to the hospital and its staff and use them well than it is to use specific techniques which may be academically advised but unfamiliar. An ether anesthesia, competently used, is far more valuable than the much lauded caudal in inexperienced or minimally experienced hands where drops in blood pressure may precipitate congestive failure.

The same is true of delivery techniques. It is wiser to allow a few additional minutes of labor than to shorten it hazardously with forceps in untrained or minimally trained hands and risk extra bleeding, shock, and congestive failure.

Anesthesiologist

Gene L. D'Alessandro, M.D., Glen Ridge; Director of Anesthesia, Presbyterian Hospital Unit, United Hospitals of Newark

The anesthesia management of the cardiac patient in pregnancy usually presents no problem in the well controlled patient. It is the patient with the more severe stages of heart failure which is likely to be difficult to manage. In the first stage of labor, the patient must receive good relief from pain and emotional distress, adequate oxygenation and avoidance of straining. The relative merits of regional and general analgesia for the second half of labor and of delivery has its advocates. The final choice of anesthesia will depend upon the emergency of the delivery and the skill and availability of the anesthesiologists.

Cardiologist

Joseph M. Stein, M.D., Associate Attending in Cardiology, Our Lady of Lourdes Hospital, Camden

In the management of heart disease and pregnancy the cardiac problem must be a paramount issue. A thorough knowledge of the hemodynamic changes in pregnancy is essential. These changes may simulate signs and symptoms of heart disease or of congestive failure. Inevitably, these changes increase the work load upon the heart and failure closely parallels these physiologic changes. A consideration of these physiologic changes and the management based thereon is considered in this discussion.

10:40 a.m.

Symposium on Gynecologic and Anesthetic Problems of Elderly Cardiacs

Moderator

Humbert L. Riva, M.D., Short Hills; Professor and Chairman, Department of Obstetrics and Gynecology, Seton Hall College of Medicine, Jersey City

Gynecologist

Peter J. Bonanno, M.D., Chief of Gynecology, Holy Name Hospital, Teaneck

The number of people over 60 years of age is rapidly increasing and will continue to increase as life expectancy increases. Fourteen per cent of all major gynecological surgery was done on patients over sixty. Types of geriatric problems are reviewed. Elderly patients do surprisingly well. Since most gynecological geriatric surgery is not emergency surgery, patients are in relatively good condition and the mortality and morbidity is unexpectedly low.

The gynecologist should weigh life expectancy against what he hopes to accomplish with a contemplated surgical procedure. He should not adopt an attitude of hopelessness because of the patient's age.

Anesthesiologist

Irving M. Riffin, M.D., Upper Montclair; Director, Department of Anesthesiology, St. Vincent Hospital, Montclair

The anesthesiologist is confident that he can bring the elderly cardiac gynecologic surgical patient through the stress of operation except when there is a history of angina pectoris or a recent coronary occlusion or congestive heart failure.

Pre-operative evaluation of blood volume and cardiac functional status is cardinal. Minimal sedation before the surgical procedure is advisable. The anesthetic should preferably be regional nerve block. However, a light general anesthetic with smooth induction and meticulous attention to signs of impending failure and replacement of blood loss can carry cardiac patients through the stress of surgery.

Postoperative ventilation and indications for electrocardiogram will be stressed.

Cardiologist

Mortimer L. Schwartz, M.D., Maplewood; Associate Professor of Medicine, Seton Hall College of Medicine, Jersey City

The benefits of gynecologic diagnostic and therapeutic measures including surgery are available even to the elderly patient with cardiovascular disease if she is treated as a complete entity rather than as an individual with a single specific complaint. A more normal cardiovascular status is regained if the physician corrects the anemia and vitamin deficiency and eliminates infection. The etiology and extent of the cardiovascular disease should be established, incipient or imminent congestive failure recognized and knowledge of the patient's diet and drug therapy documented. Type of anesthesia, positioning of the patient, parenteral therapy, fluid and electrolyte balance, avoidance of hypotension and arrhythmias plus their management require careful consideration.

11:15 a.m.

Visit to Exhibits

MEDICINE, METABOLISM, PSYCHIATRY AND NEUROLOGY

Joint Session

Medicine

WALTER R. EDWARDS, M.D., Chairman, Trenton
PETER H. MARVEL, M.D., Secretary, Northfield

Metabolism

GABRIEL PICKAR, M.D., Chairman, Highland Park
WERNER J. HOLLENDONNER, M.D., Secretary, Trenton

Psychiatry and Neurology

J. LLOYD MORROW, M.D., Chairman, Passaic
DAVID J. FLICKER, M.D., Secretary, Newark

9:30 a.m.

Election of Officers

9:40 a.m.

Symposium on Endocrinopathy

Medical Aspects

Herbert Kupperman, M.D., Associate Professor of Medicine, New York University Medical Center; and Endocrinologist, Bellevue Hospital, New York, N. Y.

The most common problems associated with an endocrinopathy are those relative to the thyroid gland and gonads. Growth problems in children and adrenocortical disease, while not as prominent as

the above, are sufficiently disturbing to make the clinician cognizant of these abnormalities. The management of thyroid dyscrasias is comparatively simple but requires adequate diagnostic procedures. The newer crystalline thyroid preparations, in contrast to U.S.P. thyroid, are more desirable due to a greater constancy and predictability of effect. The problems of gonadal dysfunction in the female are primarily concerned with menstrual abnormalities. Here, too, their management by adequate diagnostic procedures is necessary so that appropriate treatment can be instituted. The gonadal problems in the male, while not as common, are much more difficult to manage. Patients with oligospermia are the most difficult to treat as far as disturbances of gonadal function are concerned. The present availability of various diagnostic procedures plus the use of immunological techniques to determine the hormone levels of both pituitary and adrenal hormones has made the problems of growth and adrenal disease easier to recognize and manage. There is still much to be desired with respect to therapy for growth retardation. Human growth hormone is by far the most effective agent but is not readily available for all patients and may not be effective in the management of all types of growth deficiency. The medical control of excessive growth is a comparatively easy problem for the endocrinologist to manage at the present time. The use of adrenocortical steroids in the management of both excessive function and hypofunction has made adrenal problems comparatively easy to control. Overactivity of the Cushing-like modality still requires, in a great majority of the patients, a bilateral adrenalectomy for effective management. As can be seen, only some of the major problems seen in endocrinology are touched upon at the present time. Obviously, in a review such as this, details cannot be ascribed to and only the basic fundamentals will be discussed.

Metabolic Aspects

Leonard V. Fisher, M.D., Clinical Assistant Professor of Medicine, Seton Hall College of Medicine, Jersey City; and Director of Biochemistry and Endocrinology, St. Michael's Hospital, Newark

The two major regulatory systems of the body, endocrine and nervous, influence each other's activity normally and in pathologic states.

In this discussion, current concepts of neural influences on the pituitary will be briefly reviewed. Also, the effects on the nervous system, especially at a cellular level, of hormones from thyroid, gonads and adrenal will be discussed.

Neurological Aspects

David J. Flicker, M.D., Newark; Associate Professor of Neurology, New York University School of Medicine, New York, N. Y.

A brief conspectus is presented of some of the neurologic concomitants and complications of endocrinopathy. Some of the better known involvements such as diabetic neuropathy, pituitary region symptomatology and tetany are touched upon as well as some lesser known syndromes such as intermittent paralysis and chronic adrenal insufficiency, and idiopathic hypoparathyroidism presenting as chorea.

Psychiatric Aspects

Allen A. Welkind, M.D., Maplewood; Research Associate, Seton Hall College of Medicine, Jersey City

Endocrine disorders produce specific and nonspecific psychological reactions. Adrenal and thyroid abnormalities, through changes in rate and quantity of secretion, can simulate emotional states. Pituitary and gonadal dysfunction can both directly and indirectly cause psychological problems. These will be discussed with special emphasis on some gonadal effects which involve the entire organization of the psychological structure, and specific sexual development and orientation. Also to be discussed is the effect of acute and chronic stress on the endocrine functions.

Question and Discussion Period

11:45 a.m.

Visit to Exhibits

RHEUMATISM

Irving L. Sperling, M.D., Chairman, Maplewood
Edwin S. Woolbert, M.D., Secretary, Pleasantville

9:30 a.m.

Election of Officers

9:40 a.m.

Symposium on the Management of Everyday Problems in the Treatment of Arthritis and Rheumatism

Moderator

Irving L. Sperling, M.D., Maplewood; Attending in Arthritis, St. Barnabas Medical Center, Newark

Non-Articular Rheumatism—Tendinitis, Bursitis, etc.

William D. Kimler, M.D., Acting in Rheumatology, Camden Municipal Hospital

A presentation of the various types of nonarticular rheumatism, tendinitis, bursitis, capsulitis, myositis, with a discussion of the various methods of attacking the problems presented. Systemic medication, local injection, physical therapeutic measures and corrective exercise will be discussed.

9:50 a.m.

Gout—Acute and Chronic

John Lansbury, M.D., Professor of Clinical Medicine, and Chief, Section on Connective Tissue Diseases, Temple University School of Medicine, Philadelphia, Pa.

A number of potent drugs, both old and new, now permit very satisfactory management of most cases of gout. Poor therapeutic responses are commonly due to faulty diagnosis, poor cooperation on the part of the patient, or to impaired renal function. In addition, poor responses may often be attributed to incorrect dosage and timing, even though the right drugs are being used.

Diagnostic aids and some simple rules for treatment will be discussed.

10:15 a.m.

Degenerative Arthritis

Lawrence J. Denson, M.D., Chief, Arthritis Clinic, Hackensack Hospital

Osteoarthritis (Degenerative Joint Disease) is undoubtedly the most common form of joint disease encountered in rheumatology. The cause, although commonly accepted to be "wear and tear" is still basically unknown. It might be added that as a corollary, treatment is at present not completely satisfactory and can be divided into four main categories, viz: analgesia, physical therapy, local joint steroid therapy, and surgery.

In this presentation the following forms of degenerative joint disease will be discussed since they represent the most common forms of Degenerative Joint Disease encountered in clinical practice.

1. Cervical osteophytosis
2. Heberden's nodes
3. Degenerative disease of the hip
4. Degenerative disease of the knees

10:25 a.m.

Rheumatoid Arthritis—Including the Newer Therapeutic Agents

Richard H. Freyberg, M.D., Clinical Professor of Medicine, Cornell University Medical College; and Director, Department of Rheumatic Diseases, Hospital for Special Surgery, New York, N. Y.

The objective of management of patients with rheumatoid arthritis will be set forth, emphasizing the dependable therapeutic measures of proved value. The controversial procedures of limited value and/or potentialities for serious complicating side effects will be critically appraised and discussed, along with some of the newer recommended treatments still being evaluated.

10:50 a.m.

Rheumatoid Variants

John J. Calabro, M.D., Associate Professor of Medicine, and Director, Division of Rheumatology, Seton Hall College of Medicine, Jersey City

Some of the more striking clinical and radiologic manifestations of various rheumatoid "variants" will be reviewed. The entities to be discussed will include juvenile rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthropathy, Sjogren's syndrome, Felty's syndrome and Reiter's syndrome.

11:00 a.m.

Panel Discussion—Questions and Answers to Therapeutic Problems

11:45 a.m.

Visit to Exhibits

Monday Afternoon, May 13, 1963

ALLERGY, CHEST DISEASES, RADIOLOGY

Joint Session

Allergy

SYDNEY F. SMITH, M.D., Chairman, Highland Park
ARTHUR A. GOLDFARB, M.D., Secretary, Teaneck

Chest Diseases

THOMAS J. ORMSBY, M.D., Chairman, Newark
SANFORD M. LEWIS, M.D., Secretary, Newark

Radiology

LEONARD S. ELLENBOGEN, M.D., Chairman
Atlantic City
W. LAURENCE BONNET, M.D., Secretary, Trenton

2:00 p.m.

Election of Officers

2:10 p.m.

Stinging Insect Allergy

Harry L. Mueller, M.D., Clinical Associate in Pediatrics, Harvard Medical School; and Allergist-in-Chief, Children's Hospital Medical Center, Boston, Mass.

Discussor: Edward E. Seidmon, M.D., Plainfield

The differentiation between toxic and allergic reactions to insect stings, diagnosis and treatment of systemic anaphylactoid reactions to stings of hymenoptera and results over a fifteen-year period in several hundred patients will be reported and discussed with particular emphasis on the symptomatic treatment of the acute reaction and on the simplification of desensitization treatment.

2:50 p.m.

Clinical Estimation of Breathlessness

Burton M. Cohen, M.D., Elizabeth; Clinical Assistant Professor of Medicine, Seton Hall College of Medicine; and Associate Director, Thomas J. White Cardiopulmonary Institute, Jersey City

Clinical assessment of a patient's complaint of breathlessness may frequently disagree with ob-

jective tests of lung function. Despite progress in our understanding of dyspnea, little attention has been directed to developing the historical data gathered from the patient concerning his dyspnea and its circumstances of occurrence. This presentation correlates ventilation studies of ambulatory patients with bronchopulmonary diseases with performance of the "Snider Match Test" and the criteria for the severity of dyspnea suggested by the British Medical Research Council (Fletcher schema). The data indicate that careful appraisal by the physician of the patient's story is useful in estimting ventilatory disability; joint application of the Fletcher criteria and performance of the match test enhance the reliability of this clinical functional estimate.

3:05 p.m.

Management of the Breathless Patient

Stephen McC. Ayres, M.D., Westfield; Assistant Professor of Medicine, Seton Hall College of Medicine, Jersey City

Discussor: Herman Sobol, M.D., Newark

Obstructive pulmonary emphysema is the most common non-cardiac cause of shortness of breath seen in clinical practice. Successful therapy depends upon an understanding of the underlying pathophysiology. The central defect is obstruction of the smaller bronchioles probably due to the interaction of a variety of inspired pollutants (tobacco, sulfur dioxide, dust, microbial agents, etc.) and a susceptible bronchial mucosa. Dyspnea, chronic cough, and mild anoxemia characterize the earlier phases; marked anoxemia, hypercapnia and hypoventilation may complicate the later stages. Early therapy should include nebulized bronchodilators, removal of pollutants from environment and treatment of pulmonary infections; therapy in the later stages must include assisted ventilation to maintain arterial oxygen tension at an adequate level and to facilitate clearance of carbon dioxide.

3:25 p.m.

Teaching Aspects of the Chest X-ray

Roy R. Greening, M.D., Professor of Radiology, The Jefferson Medical College of Philadelphia, Pa.

4:15 p.m.

Visit to Exhibits

DERMATOLOGY

John R. Tobey, M.D., Chairman, Newark
Seymour L. Hanfling, M.D., Secretary, East Orange

2:00 p.m.

Election of Officers

2:10 p.m.

Diagnostic Skin Manifestations of Gastrointestinal Diseases

M. H. Samitz, M.D., Assistant Professor of Dermatology, University of Pennsylvania School of Medicine, Philadelphia, Pa.

Reactions on the skin may serve as windows through which changes in the gastrointestinal are observed. These relationships will be demonstrated by a group of slides selected with primary emphasis on clinical application. Skin lesions in association with avitaminoses, the malnutrition syndrome, ulcerative colitis, diseases of the hepatobiliary tract, gastrointestinal malignancies and gastroinestinal hemorrhages will be reviewed. Also included are heritable diseases affecting the skin and the gastrointestinal tract and the involvement of these organs in various systemic diseases.

2:45 p.m.

Dermatologic Problems of the Elderly

Emanuel M. Satulsky, M.D., Attending in Dermatology, The Elizabeth General Hospital and Dispensary

The normal cutaneous changes in the skin of the elderly, although of many types, are basically degenerative. This paper will serve as a reminder that the skin is often a mirror reflecting internal disease and morbid processes in addition to serving as a protective barrier between man and his environment, and is thus subject to all manner of noxious influences. It will discuss new growths of the skin in the elderly with particular emphasis on seborrheic and senile keratoses. The probem of pruritus and its management, proper management of Herpes Zoster, the use of animal skins to prevent decubitus ulcerations, genital lesions peculiar to elderly women, stasis dermatitis and leg ulcers, indications for biopsy of the skin will be discussed. This paper will make a plea that clinical dermatologists devote their efforts to treating elderly patiens with therapeutic measures of established merit and to avoid becoming investigators of every new drug and proprietary preparation.

3:15 p.m.

The Use of Hypnosis in the Treatment of Warts

E. William Jewell, M.D., Assistant Attending in Internal Medicine (Dermatology), The Valley Hospital, Ridgewood

Within recent years there has been a revival of interest in the medical use of hypnosis. It is common knowledge that warts have capricious habits. Modern techniques have shown them to be the result of a virus infection of the skin. Nevertheless, it is an accepted medical practice, and is well entrenched in folklore, that warts are subject to cure by suggestion. This is a discussion of three years private practice experience in the treatment of problem wart cases by hypnotic suggestion. One hundred twenty one cases are reviewed, and advantages and disadvantages of this modality of treatment are discussed.

3:45 p.m.

Mycosis Fungoides—Veterans Administration Film Production

Marvin N. Solomon, M.D., Chief, Department of Pathology, The Newcomb Hospital, Vineland

The motion picture film discusses the historical development, classification, clinical and histopathological features of mycosis fungoides; emphysis histological criteria for diagnosis, shows clinical appearance of the pre-mycotic and ulcerative phases of the disease and follows a case over a four-year period from early pre-mycotic to autopsy findings.

4:15 p.m.

Visit to Exhibits

PEDIATRICS, SURGERY

Joint Session

Pediatrics

William J. Farley, M.D., Chairman, Nutley
Avrum L. Katcher, M.D., Secretary, Flemington

Surgery

Raymond E. Banta, M.D., Chairman, Ridgewood
James B. Cummins, M.D., Secretary, Morristown

2:00 p.m.

Election of Officers

2:10 p.m.

Symposium on the Severely Injured Child

Pediatric Evaluation of the Injured Child
Theodore Kushnick, M.D., Linden; Assistant Professor of Pediatrics, Seton Hall College of Medicine, Jersey City

Various highlights are presented in the pediatric evaluation of the injured child. General immediate care, including external cardiac massage, and initial emergency treatment techniques are summarized. Subsequent discussion concerns itself with specific measures such as intravenous urea and hypothermia for the patient with the head injury; and the use of blood and intravenous fluids in the care of the patient with hemorrhage, anuria and burns.

It is felt that the continued critical evaluation of old and new techniques by the surgeon and pediatrician together will enable them to save more of these children.

2:30 p.m.

Diagnostic Problems of Child Injuries

C. Buckman Katzenbach, M.D., Assistant Director of Surgery, Hunterdon Medical Center, Flemington

A discussion of the difficulties in the diagnosis of the severely injured child. To include the problems of history, examination, and early laboratory confirmatory aids.

2:40 p.m.

Surgical Treatment of Abdominal Injuries in Childhood and Their Complications

Celestino Clemente, M.D., Glen Ridge; Director, Department of Surgery, Babies' Hospital Unit, United Hospitals of Newark

The early recognition and treatment of intra-abdominal injuries is emphasized. It is stated that all cases of penetrating wounds of the abdomen should be explored. The procedure for adequate observation of children who have sustained blunt trauma to the abdomen is outlined and the criteria for exploration are listed. The surgical handling of the most commonly sustained injuries is discussed.

3:10 p.m.

Head Injuries in Infancy and Childhood

Ernest S. Mathews, M.D., Assistant Attending in Neurosurgery, Morristown Memorial Hospital

The paper emphasizes the value of understanding a child with a head injury whether it be seemingly of minor consequence, therefore hoping to outline a method of management of such injuries to prevent critical complications. The paper will include comments on the neurological examination, significant changes in the neurological examination that can be examined at the bedside, as well as re-emphasizing the importance of various diagnostic measures that should or should not be carried out, and certain phases of care of the acute head injury. Finally, the paper deals with chronic comatose head injury; some aspects of management including hypothermia and rehabilitation.

3:30 p.m.

The Injured Child in the Emergency Room

Andrew C. Ruoff, III, M.D., Director, Department of Orthopedic Surgery, Chilton Memorial Hospital, Pompton Plains

The formal portion of the symposium will be concluded with a discussion of Emergency Room facilities necessary for the adequate care of the severely injured child with special reference to the problems involved in the handling of multiple fractures and combined systems injuries.

3:50 p.m.

Round Table Discussion

4:15 p.m.

Visit to Exhibits

5:00 p.m.

Organization Meeting of School Physicians

Tuesday, May 14, 1963

SPECIAL SCIENTIFIC SESSION

Arranged and presented in cooperation with The Academy of Medicine of New Jersey, and the New Jersey State Department of Health.

9:30 a.m.

Symposium on the Office Diagnosis of Cardiac Disease

Moderator

David Roth, M.D., Attending in Medicine, Barnert Memorial Hospital, Paterson

The Office Diagnosis of Congenital Heart Disease

Arthur Grishman, M.D., Associate Attending in Medicine (Cardiology), The Mount Sinai Hospital, New York, N. Y.

Congenital heart disease can be diagnosed in the office with a high degree of accuracy, as to type of lesion and assessment of dynamic degree. Judicious evaluation of history, physical inspection and palpation are important. With our knowledge of precise auscultation, electrocardiography, x-ray examination of the heart, a satisfactory group classification can be accomplished in almost all and a precise diagnosis in most.

10:00 a.m.

The Diagnosis of Early Atherosclerotic Disease

William Likoff, M.D., Professor of Clinical Medicine, and Head, Cardiovascular Section, Department of Medicine, The Hahnemann Medical College and Hospital, Philadelphia, Pa.

Although marked advances in concept and technology have been recorded within the past decade relative to the problem of atherosclerosis, the diagnosis of early phases of this disease is extremely difficult. Since a major cause of atherosclerosis is believed to be a lipid metabolic error, biochemical variations in the lipid components of the blood stream may be accepted as presumptive evidence of atherosclerosis provided that other conditions reponsible for this abnormality are not present.

An abnormal radioactive fat tolerance study likewise may be accepted in the same light. Direct visualization of blood vessels utilizing radio-opaque media is an obvious and direct method of recognizing atherosclerosis provided the process has already reached a stenosing proportion.

Finally, the diagnosis may occasionally be made on the basis of clinical manifestations when the organ or tissue involved has such an important function that alterations in this function can be recognized immediately.

10:30 a.m.

Recess for Visit to Exhibits

11:00 a.m.

The Differential Diagnosis of Hypertensive Disease

John H. Moyer, 3rd, M.D., Professor of Medicine; Chairman, Department of Medicine, The Hahnemann Medical College and Hospital, Philadelphia, Pa.

There is adequate evidence that blood pressure elevation per se produces generalized vascular damage. Available information indicates that the diathesis of essential hypertension is an inherited characteristic, but the precipitating factors responsible for its overt development are largely unknown. A careful history and physical examination are especially helpful in evaluating not only the degree of vascular damage but also the actual cause of blood pressure elevation when this can be determined—for example, adrenomedullary or adrenocortical tumors, renal vascular occlusive disease. In addition, laboratory procedures and special diagnostic studies should be carried out as indicated by the history, rather than routinely. These include renal vascular visualization, electrolyte studies, differential renal function tests, renal excretory bioassays, studies related to the status of the cardiovascular system, and radio-isotope studies.

11:30 a.m.

Open Discussion and Questions from the Floor

2:00 p.m.

Current Concepts of the Treatment of Strokes—Diagnostic and Therapeutic Problems

Moderator

M. Bernard Winkler, M.D., Attending in Neurosurgery, Barnert Memorial Hospital, Paterson

The Problem of Strokes in the Young Adult

Richard A. Chambers, M.D., Professor of Neurology, Seton Hall College of Medicine, Jersey City

This paper gives an account of the vascular lesions of the nervous system, in a selected group of patients, seen by the Neurology Service at the Jersey City Medical Center in the last year. The group under discussion are patients less than 45 years of age.

This series will be compared with the relatively few other reports of vascular lesions in this age group and the findings discussed.

2:30 p.m.

Indications and Limitations of Angiography in the Stroke Patient

Robert A. Kuhn, M.D., Head, Division of Neurosurgery, Department of Surgery, All Souls Hospital, Morristown

Cerebral angiography by indirect injection should be utilized as a routine, sometimes emergent diagnostic measure in all but a very small percentage of stroke patients. Indirect visualization of neck-to-brain arteries is mandatory in view of its proved safety and its high accuracy in clearly defining surgically treatable cerebrovascular lesions—in contrast to the known non-specificity of clinical diagnosis. Failure to make routine use of cerebral angiography constitutes today a serious roadblock to progress in treatment of stroke victims. A small number of technically satisfactory cerebral angiograms in patients with stroke show no apparent deviations from the normal. Implications of these "negative" studies will be discussed.

3:00 p.m.

Recess for Visit to Exhibits

3:30 p.m.

Early Management of the Stroke Patient—with Demonstration of Techniques Used

Henry H. Kessler, M.D., Medical Director, Hospital for Crippled Children, Newark; and The Kessler Institute for Rehabilitation, West Orange

The increase in life expectancy has brought with it an increase in the number of stroke cases.

Until recently the general attitude toward the stroke case has been a pessimistic one. This attitude is now changing to one of optimism through the philosophy of rehabilitation by an inter-disciplinary approach. Limited goals of self care and independence can be achieved.

In early management of the stroke case the nurse frequently assumes the responsibility of the whole rehabilitation team. This program should begin within the first 24 to 48 hours.

Thus the philosophy of rehabilitation is bringing hope to thousands of stroke victims, and has armed the physician with new tools to combat the social, economic, as well as the physiologic consequences of stroke.

4:00 p.m.

Syphilis—A Medical and Public Health Emergency

Warfield Garson, M.D., Division of Commissioned Officer Personnel, United States Public Health Service, Washington, D. C.

The high and rising incidence of infectious syphilis calls for an emergency approach to the disease by the physician and the health department. Gains are being made against epidemic syphilis in some places, but only when the medical and public health action in each early case is commensurate with the virulence of the treponeme and the promiscuous potential of the patient. It would be folly to stop short of eradication of a disease as intolerable and as susceptible to our technology as syphilis is.

Wednesday Morning, May 15, 1963

CLINICAL PATHOLOGY GASTROENTEROLOGY AND PROCTOLOGY, GENERAL PRACTICE

Joint Session

Clinical Pathology

MARVIN N. SOLOMON, M.D., Chairman, Vineland
PAUL STEINLAUF, M.D., Secretary, Paterson

Gastroenterology and Proctology

JACOB A. RIESE, M.D., Chairman, West New York
FERDINAND G. WEISBROD, M.D., Secretary. East Orange

General Practice

EDWARD M. COE, M.D., Chairman, Cranford
NICHOLAS E. MARCHIONE, M.D., Secretary, Vineland

9:30 a.m.

Election of Officers

9:40 a.m.

Symposium on Pancreatic Disease

Physiology of the Pancreas

Victor W. Groisser, M.D., Montclair; Associate Professor of Medicine, and Director, Division of Gastroenterology, Seton Hall College of Medicine, Jersey City

Knowledge of the control and the mechanism of the exocrine secretion of the pancreas (primarily lipase, amylase, and trypsin) affords the physician a means of understanding the effect of organic changes within this gland. The role of the natural humoral agents, secretin and pancreozymin in producing specific types of pancreatic secretion and the importance of the pancreatic enzymes in digestion and absorption will be stressed in this general review of pancreatic physiology. Diagnostic tests of pancreatic function may best be understood in the light of normal pancreatic physiology.

9:55 a.m.

Laboratory Diagnosis of Pancreatic Disease

Robert L. Breckenridge, M.D., Assistant Professor of Pathology, The Jefferson Medical College of Philadelphia, Pa.; and Attending in Pathology, Our Lady of Lourdes Hospital, Camden

The diagnosis of diseases of the pancreas requires the finding of some abnormal laboratory data in tests pertaining to this organ. Enzymatic

activity tests, particularly the serum amylase, are very significant in the diagnosis of acute pancreatitis. In chronic diseases of the pancreas the Secretin test, including cytologic studies, offers the most direct means of arriving at a diagnosis. The sweat test is the keystone in the diagnosis of cystic fibrosis. These and other laboratory procedures commonly used in the diagnosis of pancreatic disease will be discussed.

10:10 a.m.

Acute and Chronic Pancreatitis

Harry Shay, M.D., Professor of Clinical Medicine, and Director, Fels Research Institute, Temple University School of Medicine, Philadelphia, Pa.

Chronic relapsing pancreatitis is probably the commonest misdiagnosed or undiagnosed disease of the upper abdomen. This is in part due not only to the inaccessibility of the organ for examination and the difficulties in evaluating function of the pancreas, but also to a low index of suspicion on the part of the physician with regard to chronic disease of this organ. Especially is the last true for the milder forms of the disease. An adequate and practical pancreatic function evaluation and a useful medical regimen with emphasis on the milder forms of pancreatitis wil be discussed.

10:35 a.m.

Cystic Fibrosis

Guilio J. Barbero, M.D., Assistant Professor of Pediatrics, University of Pennsylvania School of Medicine; and Senior Physician, Children's Hospital, Philadelphia, Pa.

Cystic fibrosis of the pancreas is a generalized disease of the exocrine glandular system. Its principal manifestations are more frequent foul stools and recurrent signs of respiratory involvement such as cough, dyspnea and wheezing. The diagnostic tools are the sweat test and measurement of pancreatic enzymes. Treatment consists of intensive antibiotic administration, pulmonary physiotherapy, and, in certain instances, nocturnal mist therapy.

11:00 a.m.

Clinical Diagnosis of Pancreatic Cancer

Benjamin J. Macchia, M.D., Clinical Assistant Professor of Medicine, Seton Hall College of Medicine, Jersey City

Malignancy of the pancreas esp. the early anicteric form is most difficult to diagnose correctly because of its protean manifestations. However, there does exist a diagnostic clue, if sought for, in the positional relief of pain. The majority of these patients at some time in the course of the disease will assume a very characteristic posture to ease their pain. Cases illustrating this trunk-knee flexion sign will be presented and discussed.

11:15 a.m.

X-ray Diagnosis of Pancreatic Diseases

Leo H. Siegel, M.D., Attending in Gastroenterology, Presbyterian Hospital Unit, United Hospitals of Newark

Radiological diagnosis of gastrointestinal diseases in general has shown considerable advance over the years; but the pancreas, occupying its secretive position against the upper posterior abdominal wall, continues to resist attempts to visualize it accurately.

Large pancreatic lesions may cause extrinsic pressure or displacement and thereby be identified. However, the all-important small, and therefore potentially curable, lesion remains difficult or impossible to demonstrate radiographically.

The clinician interested in the early diagnosis of pancreatic disease will have to train himself to look for subtle changes in surrounding structures suggesting localized pressure or invasion. He will also have to identify evidence of alterations in gastrointestinal function due to pancreatic disease.

Techniques will be discussed and illustrative cases presented.

11:30 a.m.

Question and Answer Period

Moderator
Robert L. Breckenridge, M.D., Camden

11:45 a.m.

Visit to Exhibits

ORTHOPEDIC SURGERY, UROLOGY

Joint Session

Orthopedic Surgery

William J. D'Elia, M.D., Chairman, Spring Lake
Daniel J. O'Regan, M.D., Secretary, Jersey City

Urology

Harold Rubin, M.D., Chairman, Long Branch
Bernard M. Kramer, M.D., Secretary, Perth Amboy

9:30 a.m.

Election of Officers

9:40 a.m.

Symposium on the Pathology of Low Back Pain

Moderator
William J. D'Elia, M.D., Spring Lake; Attending in Orthopedic Surgery, Fitkin Memorial Hospital, Neptune

Orthopedic Problems

Vincent A. Scudese, M.D., Newark; Director, Department of Orthopedic Surgery, Jersey City Medical Center

The low back region is of great interest to the orthopedic surgeon. It is imperative that the anatomy, physiology and biomechanics be thoroughly understood in order to interpret the pathology. The region is divided into the lumbar, lumbar sacral and sacral iliac areas.

Low back pain has always been and still is an important affection of mankind. The chief types of lesions from an etiologic standpoint are mechanical, traumatic, infectious and neoplastic. Among the most important conditions causing low back pain are lesions of the intervertebral discs, arthritis, tuberculosis, osteoporosis, osteomyclitis, fractures, spina bifida occulta, spondlolisthesis and improper posture.

Urological Aspects

Milton L. Lieberman, M.D., Associate Attending in Urology, Alexian Brothers Hospital, Elizabeth.

The paper presents a brief outline of the nerve supply of the urinary tract. With a better knowledge of the pain pathways, we can recognize how many abnormal conditions, including the urinary tract can cause discomfort. The final portion of the paper is devoted to describing some of the more common diseases of the urinary tract responsible for back pain.

Surgical Aspects

John L. Costello, M.D., Attending in Surgery, Jersey City Medical Center

Etiology of low back pain from a surgical standpoint is often extremely difficult to elicit. It is mandatory that a very thorough history be obtained and a complete physical examination undertaken with careful attention given to the abdomen, pelvis and rectum. Unless the condition provoking the low back pain is very obvious one must proceed with extreme caution lest the causative factor be overlooked. In all cases, one must work closely with one's colleagues; namely the gastroenterologist, urologist and the orthopedic surgeon: but most importantly, in cases in which the etiology is most obscure. Cases are presented herewith where the diagnosis may be made with the diligent use of all our ancillary armamentarium.

Neurosurgical Problems

Gerald F. Whalen, M.D., Red Bank; Attending in Neurosurgery, Monmouth Medical Center, Long Branch

Panel discussion following individual presentation: differential diagnosis of primarily neurological and/or neurosurgical disease from orthopedic abnormality; selection of cases of presumed intervertebral disc herniation for myelography and surgical intervention.

Round Table Discussion—Questions and Answers

11:45 a.m.

Visit to Exhibits

OPHTHALMOLOGY

Alfonse A. Cinotti, M.D., Chairman, Jersey City
William Rubin, M.D., Secretary, New Brunswick

9:30 a.m.

Election of Officers

9:40 a.m.

Symposium on Refinements in Ocular Surgery

Moderator

Alfonse A. Cinotti, M.D., Clinical Assistant Professor of Ophthalmology, Seton Hall College of Medicine, Jersey City

Corneal Surgery

Jorge N. Buxton, M.D., Director, Corneal Clinic, New York Eye and Ear Infirmary, New York, N. Y.

Needles and suture material available for this type of surgery. Advantages and disadvantages of different types. Complications. Techniques for removal and variations in postoperative care and followup.

Gunderson conjunctival flaps. Techniques. Indications and contraindications.

Descending bullous keratitis after cataract extraction. Etiology, progression, surgical techniques available.

Present status of keratoprostheses with and without corneal grafting. Indications. Complications.

Retinal Surgery

John C. Leaman, M.D., New York, N. Y.; Director, Retinal Clinic, Jersey City Medical Center

This will be a discussion of the diagnosis of retinal disease and detachments, the use of the indirect binocular ophthalmoscope, the slit lamp and contact lens. We shall include a study of the vitreous and other prognostic factors in retinal detachments. The modern surgery of retinal detachment and other lesions, covering the use of silicone plastic in scleral buckling procedure as well as liquid silicone in vitreous implants, and finally, the use of the photo-coagulator will be discussed. Slides will be used when possible to illustrate important points.

Strabismus Surgery

Paul T. McAlpine, M.D., Attending in Ophthalmology, Overlook Hospital, Summit

This will not be a formal paper but a discussion and emphasis of certain factors which have been of help in strabismus surgery. Included in this are a few observations concerning the rationale of a-v phenomena surgery; suture placement and material; a method of engaging the muscle tendon on a squint hook of value in certain instances.

Cataract and Glaucoma Surgery

Arthur E. Sherman, M.D., East Orange; Attending in Ophthalmology, The Hospital Center at Orange

Cataract and Glaucoma Surgery—Part of a Symposium on Refinements in Ocular Surgery. The changes and improvements in cataract and glaucoma surgery during the past decade will be reviewed. The present-day technic of a number of cataract and glaucoma operations will be discussed including pre-operative preparation and postoperative care.

11:45 a.m.

Visit to Exhibits

1:00 p.m.

Luncheon and Meeting—New Jersey Academy of Ophthalmology and Otolaryngology

Reservations: Mr. Randall Norris
367 New Bridge Road,
Bergenfield

OTOLARYNGOLOGY

ARIS M. SOPHOCLES, M.D., Chairman, Trenton
JAMES H. SPILLANE, M.D., Secretary, Phillipsburg

9:30 a.m.

Election of Officers

9:40 a.m.

Symposium on Hearing Loss in School Children

Moderator

Aris M. Sophocles, M.D., Attending in Otolaryngology, The Mercer Hospital, Trenton

Nerve Deafness

Joseph Sataloff, M.D., Associate Professor of Otolaryngology, Jefferson Medical College Hospital, Philadelphia, Pa.

Nerve deafness is one of the most challenging problems confronting otologists. All children with slow speech development, certain speech and voice defects, and chronic inattention should have hearing tests. A valid diagnosis is essential based on the following tests: (1) air and bone conduction audiometry with masking, (2) discrimination, (3) recruitment, and (4) tone decay studies. These tests will be discussed and their pitfalls portrayed in clinical case reports. The causes of nerve deafness in children and their management in office practice will be elaborated.

Congenital Ear Defects

F. Robert Haase, M.D., Attending in Otolaryngology, Fitkin Memorial Hospital, Neptune

This paper deals with the classification of congenital deafness and the entities falling within these classifications. Statistically the greater portion of the conditions causing congenital deafness should be controllable or preventable. The author wishes to emphasize this aspect and the significance of early prevention to society as well as the patient.

Secretory Otitis

Joseph R. Burns, M.D., Attending in Otorhinolaryngology, The Mercer Hospital, Trenton

Screening Tests

William L. Wood, M.D., Attending in Otolaryngology, Riverview Hospital, Red Bank

The major goal of the hearing-screening program in schools is the early identification of children with hearing impairment and prompt medical direction.

Since it is impossible to test each child each year, children in grades one through twelve shall be tested at least once every three years.

A Sweep Test is done using the two frequency technique testing frequencies 2000 and 4000 CPS at the 15 Db level. A child failing the Sweep Test is given a follow-up diagnostic puretone threshold examination. This measures the child's threshold at each of the standard audiometric frequencies.

Children failing the diagnostic puretone threshold examination should be referred through the family to an otologist for a complete otologic and audiometric examination.

11:45 a.m.

Visit to Exhibits

1:00 p.m.

Luncheon and Meeting—New Jersey Academy of Ophthalmology and Otolaryngology

Reservations: Mr. Randall Norris
367 New Bridge Road,
Bergenfield

Educational Exhibits

Exhibit Hours:

9:00 a.m. - 5:00 p.m., Monday and Tuesday, May 13 and 14, 1963

9:00 a.m. - 1:00 p.m., Wednesday, May 15, 1963

Booth E-101. The Society for the Relief of Widows and Orphans of Medical Men of New Jersey—Belleville

This Society can well be described as a real "Helping Hand Organization." It provides a sum to help carry the deceased member's family over this difficult time when ready money is not available or until the member's estate is settled. Every physician in good standing in the State of New Jersey is eligible to membership. At small cost he can help to provide aid to a professional brother in distress or to his family, and when a member dies, it is comforting to know he has helped provide financial assistance to the bereaved and often-times very needy family. Some members even transferred their benefits to the Permanent Fund to further aid those unfortunate ones.

After you have been elected a member, change of residence does not affect membership. Once a member always a member, if the assessments are paid.

Booth E-102. Visiting Homemaker Services—Visiting Homemaker Association of New Jersey, Inc., Trenton

Visiting Homemaker Service is a non-profit, health oriented agency which has available carefully selected, mature qualified women, trained to serve in homes disrupted or overburdened by illness. This community program releases hospital beds for the acutely ill, prevents unnecessary institutional care, prevents absenteeism in school and industry, and provides for the maintenance of a well-organized household.

Booth E-103. Consultation Service for Convulsive Disorders—New Jersey Consultation Service for Convulsive Disorders, New Jersey Neuro-Psychiatric Institute, Princeton

The Service offers professional consultation for patients suffering from convulsive disorders, who cannot pay the usual private fees for such service. Clinics are held at stated intervals in designated local community hospitals throughout the State.

Booth E-104. New Jersey Rehabilitation Commission

The exhibit relates the general services of the Rehabilitation Commission for vocational rehabilitation of physical and mentally disabled individuals. Specifically, relates the medical and vocational program of a disabled individual; chronological steps from referral to agency, through medical evaluation, treatment, training, and return to employment.

Booth E-105. Diet Counseling—A New Service for Physicians—Nutrition Service, New Jersey State Department of Health, Trenton

To acquaint physicians in New Jersey with a new, fast-growing service available to them for their patients, and depicting how these services may be obtained and used.

Booth E-106. Athletic Injury Prevention the Day of the Game—Athletic Injury Prevention Committee, Bergen County Medical Society

Prevention procedures the day of the football game—Diet, Preventive strapping, Half-Time, and Football Equipment.

Booth E-107. Packaging the Passenger—William L. Sprout, M.D., Chairman, Committee on Traffic Safety, The Medical Society of New Jersey

Methods used by the auto industry since 1955 to minimize injuries produced by the "secondary collision" between occupants and the auto interior. The display includes improved door latches, steering wheels, and seat belts.

Booth E-108. JEMPAC - AMPAC—Jersey Medical Political Action Committee; American Medical Political Action Committee

Booth E-109. Civil Defense Emergency Hospital and Medical Self-Help Training Program—Committee on Disaster Medical Care, The Medical Society of New Jersey; and New Jersey State Department of Health

Minature model of 200-bed Civil Defense Emergency Hospital as it would be laid out in a high school gymnasium or large hall. Description of Medical Self-Help Training as a teaching program for high school students and the general public so that they may be able to survive a natural or man-made disaster.

Scientific Exhibits

Exhibit Hours:

9:00 a.m. - 5:00 p.m., Monday and Tuesday, May 13 and 14, 1963
9:00 a.m. - 1:00 p.m., Wednesday, May 15, 1963

Booth S-201. Nasal Secretions, Immunological States, Asthma, and Gamma Globulin—Martin Green, M.D., Betty Bacharach Home, Atlantic City; and The Jefferson Medical College of Philadelphia, Pa.; and Milton Ackerman, M.D., Atlantic City Hospital, and Betty Bacharach Home, Atlantic City

This exhibit demonstrates the clinical and cytological effects of gamma globulin in immunologically non-responsive infectious asthma. Children with infectious asthma can be divided into immunologically responsive and immunologically non-responsive asthmatic children. This division is dependent upon the status of the bacteria and cellular elements in the nasal secretions with relation to the immunological processes of phagocytosis, lysis, and agglutination of the bacteria. Conversion of immunologically non-responsive asthmatic children by adequate dosages of gamma globulin is demonstrated. Improvement in their asthma is correlated with the findings in the nasal secretions.

Booth S-202. Comprehensive Evaluation of the Handicapped Child—Avrum L. Katcher, M.D., and Beatrice F. Tileston, Hunterdon Medical Center, Flemington

Comprehensive evaluation is the basis for long-term planning and guidance for the child with handicaps. Under pediatric leadership a medically based study provides accurate description of limitations and capabilities and prediction of future growth and development. Parental understanding and expectations are assessed by the case worker who then provides support for the parents throughout the study. Facts are put together on a medical base and then translated so that parents can both understand and accept. Conclusions are interpreted to community health and educational professional workers. The necessary steps for such a program are described using a case from the files of the Hunterdon Medical Center.

Booth S-203—Current and Projected Rehabilitation Services Offered by the Betty Bacharach Home for Afflicted Children—David B. Allman, M.D., Martin Green, M.D., and Carter Zeleznik, M.A., Atlantic City

The purpose of this exhibit is to inform New Jersey physicians of the rehabilitation and convalescent services available at the Betty Bacharach Home, and to present statistical evaluations of results obtained in the various medical and surgical diseases treated at the Betty Bacharach Home in the past five years.

Booth S-204. Milk Allergy—A Collaborative Clinical, Biochemical, and Immunological Study—Armond S. Goldman, M.D., William A. Sellars, M.D., S. R. Halpern, M.D., and D. W. Anderson, Ph.D., Galveston, Texas

This exhibit will portray the clinical and serologic data which was obtained from 75 children with proved cow's milk allergy. These patients were diagnosed and studied by 17 collaborating members of the Academy of Pediatrics.

The objectives of this study were to determine (1) the relevant symptoms of milk sensitivity, (2) the allergens in cow's milk responsible for these reactions, (3) the relationship of skin testing with four isolated milk proteins to the results of their oral challenge, and (4) the serologic manifestations of milk allergy.

Patients were accepted as sensitive to milk on the basis of relief of symptoms during elimination of milk and reappearance of these same symptoms upon the reintroduction of the milk on a minimum of two occasions.

If a reproducible reaction could be produced by the oral administration of 100 ml. of skimmed milk, oral challenges with corresponding levels of casein, alpha-lactalbumin, beta-lacto-globulin and bovine serum albumin were performed to determine the relative allergenicity to each of these isolated and purified proteins. Each patient was skin tested with these proteins and a blood specimen examined for the presence of antibodies to milk proteins by the gel diffusion technique and the passive cutaneous anaphylaxis techniques in the guinea pig.

Booth S-205. The Management of Leg Cramps in Pregnancy—Herschel S. Murphy, M.D., Roselle; Stanley P. Wegryn, M.D., Elizabeth; Ernest C. Lowenstein, M.D., Rahway; and Edward J. Surowiec, M.D., Trenton

This exhibit presents the rationale for the use of isoxsuprine hydrochloride in treating leg cramps in pregnancy. Panels depict the various controversies in therapy and physiological involvement associated with prenatal leg cramps and the degree of relief obtained from therapy by distribution of dosage, age, and parity.

Booth S-206. Douching in the Treatment of Pruritus Vulvae and Vaginitis—Robert Glynn, M.D., and Aaron Lowenstein, M.D., Newark Beth Israel Hospital

Results of studies on the effect of douching on the vaginal mucosa is presented in detail. The

cytology, bacteriology and pH of the vagina has been studied after repeated and prolonged daily douching. The role of the douche as an ancillary in the treatment of pruritus volvae and vaginitis is presented. The investigators' choice of douche and rationale of such choice are also presented.

Booth S-207. The Use of the Grafenberg Ring for Contraception—Theodore D. Spritzer, M.D., Dunellen

Photographs and charts indicating the history of intrauterine pessaries for contraception. Demonstration of types of intrauterine rings in use throughout the world today. Exhibition of a modified ring used by the exhibitor with the results over a period of three years, together with the instruments necessary for its insertion and removal.

Booth S-208. Degenerative Diseases in Elderly Involving Locomotion—Francis H. Stern, M.D., Philadelphia, Pa.

With the increase in percentage of elderly people in the population comes an increasing emphasis on etiology and treatment of conditions which affect them. To keep the patient moving with a minimum of pain and spasticity becomes a prime objective in medical treatment of the elderly. In this exhibit many disabling geriatric problems of locomotion are studied along with a double blind evaluation of drug therapy to help these patients remain active in their daily life.

Booth S-209. Objective Measurement of Muscle Extensibility—Harold T. Hansen, M.D., Earl F. Hoerner, M.D., Bernard Suffel, B.S., and Patrick Trotta, B.S., New Jersey Orthopaedic Unit, Hospital Center at Orange

The exhibit presents clinical conditions of increased muscle tones which cause pain, and associated muscular skeletal conditions; physiological and pathological basis of normal increase and decrease muscular tones; and a method of objective measurement.

Booth S-210. Medical Rehabilitation of Multiple Disability—Otto Eisert, M.D., Sister Kenny—B. S. Pollak Rehabilitation Institute; and Division of Physical Medicine and Rehabilitation, Department of Medicine, Seton Hall College of Medicine, Jersey City

Rehabilitation techniques and programs utilized at the Sister Kenny—B. S. Pollak Rehabilitation Institute; demonstrations of treatments for the following conditions: hemiplegia, paraplegia, quadriplegia, amputation, fracture, arthritis, cerebral palsy, post-encephalitic syndrome. Total concept will be demonstrated. Complete hospital facilities and services of all medical specialties wil be emphasized. Teaching of the medical students of the Seton Hall College of Medicine and Dentistry will be shown to have an important part in the program.

Booth S-211. Prevention of Contractures in the Acute Phase of Strokes—Alvin Florin, M.D., Heart Disease Control Program, New Jersey State Department of Health, Trenton; and The New Jersey Academy of Medicine, Newark

To show methods of preventing contractures through care given to the stroke patient during the acute phase of the CVA. Correct equipment and techniques will be demonstrated.

Booth S-212. Advantages of Cerebral Angiography by the Retrograde Brachial Route—Robert A. Kuhn, M.D., All Souls Hospital, Morristown

Methods of cerebral angiography have passed through gradual evolution from injection of the exposed carotid artery to various transcutaneous techniques in the lower neck. Percutaneous carotid, subclavian and vertebral punctures constitute by far the most common current procedures. Percutaneous cerebral angiography carries a three to four per cent complication rate in most clinics, the local and neurological sequelae ranging from periarterial hemorrhage to death. Retrograde brachial angiography is recommended as a substitute method with many technical advantages, which will safely opacify in physiological fashion—two-thirds of the cerebral circulatory tree, without damaging its vascular trunks.

Booth S-213. Differential Diagnosis and Treatment of Hypertension—Albert N. Brest, M.D., and John H. Moyer, M.D., Hahnemann Medical College and Hospital, Philadelphia, Pa.

The known causes of diastolic hypertension include three major categories—renal, vascular, and adrenal. Approximately 10 per cent of the hypertensive population falls into this category. In 90 percent, the diastolic blood pressure elevation is essential in origin. This exhibit concerns itself with the differential diagnosis of renal, adrenal, vascular, and essential hypertension. All of the currently employed diagnostic procedures are discussed. In addition, medical and surgical management is described. Effective therapeutic measures are now available in the overwhelming majority of instances.

Booth S-214. Progress on Coronary Heart Disease—Broda O. Barnes, M.D., Denver, Colo.

Four illuminated glass panels present: (1) from 33,358 autopsies at Graz, Austria, it is seen that myocardial infarctions are inversely related to deaths from infection; (2) the underdeveloped countries have low death rates from infarctions because people die too early from infections; (3) the high death rate from infarctions in the U. S. is due to reduction in infections and better medical care; (4) diets low in saturated fats do not prevent coronary sclerosis; (5) reduction of serum cholesterol with only thyroid therapy during 13 years on over 1400 patients has markedly reduced angina,

myocardial infarctions, and deaths from coronary disease; (6)) autopsies reveal that thyroid therapy controls but does not eliminate coronary sclerosis; and (7) thyroid therapy lowers cholesterol, increases coronary blood flow, prevents thrombophlebitis, raises coagulation-time, and decreases fatigue and stress.

Booth S-215. Routine Pulmonary Function Screening in a Community Hospital—A. Marshall Smith, Jr., M.D., Sylvan E. Moolten, M.D., Walter Grossman, M.D., Lawrence L. Livornese, M.D., and John R. Helff, M.D.; Mrs. Thelma Jones and Mrs. Marjorie deGraff, Technical Assistants; Middlesex General Hospital, New Brunswick

For the past two-years, a program of routine screening for chest diseases has been carried out at Middlesex General Hospital in New Brunswick. This screening has consisted of a brief questionnaire covering respiratory history, a chest x-ray and a simple pulmonary function study giving the total vital capacity and the two-second timed vital capacity. These tests have been performed on all patients over the age of forty-five. Our results have shown a rate of abnormal findings of 30 per cent for the pulmonary function test and another 30 per cent for the chest x-ray. Although there is some overlap, the net result has been nearly 50 per cent of patients admitted to the hospital with some abnormality of heart or lungs. This information has been of great value in the management of medical patients and in the proper selection and care of surgical patients. Illustrative cases are shown with completed studies.

Booth S-216. The Evaluation of Inhaled Broncho-Dialators, Singly and in Combination—Arthur A. Goldfarb, M.D., Teaneck; and Alfred Romanoff, M.D., Lebanon Hospital, Bronx, N. Y.

The exhibit consists of charts showing the structural formula of the common sympathomimetic amines and the comparative protective effect of various antagonists of histamine-induced bronchoconstriction in the guinea pig. Objective and subjective studies with timed vital capacity of various combinations and individual bronchodilators in a double blind study are shown. Side effects of a triple combination aerosol on blood pressure and pulse are itemized. A graphic visualization of one-second timed vital capacity demonstrating the effectivenesss of the triple drug aerosol as compared to the placebo or each of the three ingredients, separately or in combination, is also charted.

Booth S-217. Adenomyoma of the Gall Bladder—John R. Helff, M.D., and Alfred E. Greenwald, M.D., Middlesex General Hospital, New Brunswick

Demonstration of the diagnosis and method employed in the condition for detection of adenomyoma of the gall bladder. The purpose of the exhibit is to indicate the symptoms of the condition, its relative frequency, and to alert the physician in methods of the diagnosis. The exhibit will consist of actual case demonstrations with radiographs, surgical specimen photographs and photomicrographs indicating the pathological nature of the diseased state of the gall bladder. This is a condition seldom recognized in routine investigation of the gall bladder disease and particularly by roentgenographic methods. Demonstration as to the methods employed to detect its presence will be given in order to familiarize the physician with this not uncommon entity.

Booth S-218. Radiological Health—James H. Gillem, M.D., Radiological Health Program, New Jersey State Department of Health, Trenton

New Jersey Radiation Protection Code and inspection procedures and some of the major violations encountered in inspection of medical equipment.

Booth S-219. Local Injections of Steroids in Dermatologic Disorders—Norman Orentreich, M.D., and Robert A. Berger, M.D., New York University Post-Graduate Medical School, New York, N. Y.

After ten years of use, and dozens of steroids and different compounds of steroids, much has been learned of the value of local injections of steroidal preparations in a variety of dermatologic disorders. Several steroids will be reviewed, and their chemistry, systemic, and dermatologic pharmacology will be demonstrated. Kodachromes of the many dermatological disorders that can now adequately be treated with such local injections will be shown, and a variety of techniques for the administration of such steroids will be reviewed.

Booth S-220. Simple Practical Procedures for Regional Chemotherapy of Cancer—Jeanne C. Bateman, M.D., and Harry N. Carlton, M.D., Washington, D. C.

A pictorial presentation of simplified techniques of administering and concentrating non-vesicant oncolytic agents into tumor sites including serous cavities, liver, and local masses. The techniques do not require hospitalization and can be repeated indefinitely. Results of such management in over 1,000 cases are indicated.

Booth S-221. Proctosigmoidoscopy for Asymptomatic Cancer—Joseph I. Echikson, M.D., Chairman, Professional Information Committee, American Cancer Society, New Jersey Division, Inc., Newark

Emphasis on the number one position of rectal and colon cancer in incidence and mortality in this country. Illustrates the relatively low percentage of cancers detectable by digital and x-ray examinations, and the high percentage (70 per cent) within reach of proctosigmoidoscopy. Presents the concept that the proctosigmoidoscopic examination is a simple procedure, which is easily learned, easily

done or, if preferred, easily referred to another physician.

Booth S-222. Family Treatment of Tuberculosis—Julius Wilson, M.D., Director of Medical Education, National Tuberculosis Association; and American Thoracic Society, New York, N. Y.

This is an exhibit to emphasize and demonstrate modern chemotherapy of the active case of pulmonary tuberculosis, the accepted procedures for identifying all of the household contacts in need of prophylactic treatment, and the best methods of applying such therapy at home.

Booth S-223. Syphilis Is Where You Find It—Roscoe P. Kandle, M.D., Commissioner, New Jersey State Department of Health, Trenton; and United States Public Health Service

Lighted color slides of syphilis lesions and other lesions involved in differential diagnosis. Text summarizes syphilis resurgence pattern in U. S. Emphasizes physician participation with public health agencies in syphilis eradication drive. Professional literature on VD will be available.

Booth S-224. The Urologic Aspects of Hypertension—Willard M. Drake, Jr., M.D., and Milton Ivker, M.D., Cooper Hospital, Camden

The exhibit demonstrates the urologic methods currently used to evaluate the hypertensive patient. Representative roentgenograms and photographs are displayed. The equipment necessary for percutaneous renal angiography is shown.

Booth S-225. Nephrotomography—James R. Marquis, M.D., and John W. Marquis, M.D., East Orange

The usefulness of nephrotomography in the general hospital is stressed. Renal mass lesions often present problems in diagnosis that usually can be resolved by this simple roentgen procedure. The characteristics of renal carcinoma and renal cysts are demonstrated by means of illustrative cases. The method of examination, indications and results are reviewed. Nephrotomography can be of considerable aid in the pre-operative exploration of the renal mass lesion.

Booth S-226. The Management of Ocular Emergencies—Dan M. Gordon, M.D., The New York Hospital, Cornell University Medical College, New York, N. Y.

The generalist can handle many ocular injuries with a minimum of equipment. Basic guideposts for evaluation of the type and degree of injury, as well as for emergency and follow-up management will be pointed out. Many of these patients, once properly evaluated, can be handled easily. Others require more specialized care. Here, too, the important diagnostic criteria are highlighted. Rules for the management of all types of ocular emergencies are stressed.

Booth S-228. Glaucoma—R. U. Stern, M.D., W. T. Rados, M.D., H. Gambacorta, M.D., H. L. Moskowitz, M.D., J. Insabella, M.D., M. Kowaleski, L. P. M., and Herbert E. Rickenberg, M.A., Department of Visual Rehabilitation, Eye and Ear Infirmary Unit, United Hospitals of Newark

This exhibit will illustrate the specialty services of an Eye Department in an Eye specialty hospital. Illustrations of caring and evaluating the glaucoma patient, orthoptic patients, and pleoptic patient will be demonstrated.

Booth S-229. Audiological Manifestations in Neuro-Otological Defects—Richard D. Swain, M.D., and Herbert E. Rickenberg, M.A., Eye and Ear Infirmary Unit, United Hospitals of Newark

This exhibit will demonstrate the results and use of audiological tests of hearing as aids for the neurologist and otologist in the ascertainment of the site of an auditory lesion. Charts of tests results and models of confirmed surgical lesions will be utilized.

Booth S-230. Otologic Diagnosis and Treatment of Deafness—David Myers, M.D., W. D. Schlosser, M.D., R. J. Wolfson, M.D., Irving Rush, M.D., R. A. Winchester, Ph.D., P. J. Melville, M.A., and B. J. Goldman, M.S., Otologic Institute, The Presbyterian Hospital, Philadelphia, Pa.

Deafness is the nation's most common physical disability. Fully 25 per cent of all non-institutionalized handicapped persons, or 3.5 per cent of the general population have a significant degree of hearing impairment. This exhibit presents the most modern diagnostic and surgical methods and procedures for the treatment of deafness and other ear disorders. It contains pictorial and graphic explanations of the techniques used. Specific attention is directed toward the accurate assessment of auditory functions and an explanation of current techniques of total stapedectomy, tympanoplasty and ultra-sonic surgery. Color photographs of middle-ear surgery, descriptions of audiologic techniques and pre- and postoperative audiograms are included.

Booth S-231. Local Anesthesia in Colorectal Surgery—Jack A. Young, M.D., Raymond M. Smith, M.D., Guy L. Kratzer, M.D., Howard D. Trimpi, M.D., Bryon D. Wilkins, M.D., Arnold Manhelm, M.D., and Franklin L. Chen, M.D., Allentown Hospital, Pa.

The advantages and disadvantages of general anesthesia, spinal anesthesia, caudal anesthesia, and local anesthesia for colorectal surgery are presented. The technique for local anesthesia is illustrated by color photographs. Illustrative cases are demonstrated. Comparison studies between the effects of isoadrenaline and epinephrine; and be-

tween procaine, lidocaine and mepivacaine were done. The experience of over 6,000 cases is presented.

Booth S-232. Nausea/Vomiting—Prophylaxis and Treatment—Carl A. Coppolino, M.D., and George Wallace, M.D., Methodist Hospital, Brooklyn, N. Y.

Postoperative nausea and vomiting, notwithstanding newer anesthetics and techniques, are still a serious complication of surgery. A controlled (double-blind technique) clinical trial was made of a new antiemetic, in 2000 patients' schedules for elective surgery. Statistical analyzed data are illustrated by tables and graphs.

Booth S-233. Percutaneous Transhepatic Cholangiography—Maxwell Borow, M.D., and John R. Helff, M.D., Middlesex General Hospital, New Brunswick

The differentiation between obstructive and hepatocellular jaundice can at times be most difficult. To complicate the situation for the surgeon certain diseases can produce an intrahepatic cholestatic form of obstructive jaundice which is not amenable to surgery. Percutaneous transhepatic cholangiography is a diagnostic procedure which will differentiate between parenchymatous and obstructive disease. Furthermore, it has been the author's experience that this test will also distinguish between intrahepatic and extrahepatic obstruction. Transhepatic cholangiography was successfully performed in every case of extrahepatic blockage, whereas it was uniformly unsuccessful in intrahepatic obstruction. Indications, technique, and complications will be presented. Case reports with history, roentgenograms, and transparency photos of pathology will be demonstrated to illustrate the advantages of this diagnostic tool, and to prove both extrahepatic obstruction and intrahepatic cholestatic jaundice. Also included will be a summary of results and conclusions.

Booth S-234. Cosmetic and Reconstructive Surgery in the Community Hospital—Lorne C. Irwin, M.D., and Walter M. Ryan, M.D., Monmouth Medical Center, Long Branch; and Fitkin Memorial Hospital, Neptune

Series of large photographs exemplifying cases seen and treated by the authors, together with a series of 80 color-slides showing routine and problem cases of plastic and reconstructive surgery treated.

Booth S-235. Evaluation for Open Heart Surgery—Ralph Lev, M.D., Paul B. Jennings, M.D., Diego DeArmas, M.D., Helene Pickholtz, B.S., and Marriann Wolczanski, R.N., St. Peter's General Hospital, New Brunswick

In the past three years we have noted in our Cardiopulmonary Unit a distinct increase in the number of patients referred for cardiac evaluation with gross misconceptions as to their need or contraindications for open heart surgery. This is, in great measure, the result of rapidly changing and improved methods for direct repair of congenital and acquired cardiac lesions. The exhibit outlines the step-by-step methods for present day study of the patient with suspected or known cardiac lesions and separates the operable from the nonoperable group in the light of our knowledge today. Medical and surgical recommendations are indicated as applicable to the individual case.

Booth S-236. Creation of a Third Coronary Artery—Victor P. Satinsky, M.D., Hahnemann Medical College, Philadelphia, Pa.

The exhibit demonstrates an experimental technique for creating a third coronary artery, utilizing the posterior sinus of valsalva as the site of origin. The effect of ligating the anterior descending coronary artery is visualized, with immediate restoration of normal rubicund coloration upon establishment of third coronary artery flow beyond the point of ligation. This procedure apparently holds promise for effective revascularization of the heart.

Booth S-237. The Modern Medical Museum in Natural Color—Martin R. Rush, M.D., Aldo G. Baldi, M.D., Salvador Borja, M.D., Alex Tschekunow, M.D., and Natalio Damien, M.D., Monmouth Medical Center, Long Branch

A broad spectrum review of gross specimens in natural color with a pathologist in attendance to discuss the clinicopathologic correlation. Demonstrations of the technique will be presented, and a comparison made with the traditional type of museum specimen.

Booth S-238. Gastric Freezing—Robert E. Rich, M.D., Theodore S. Heineken, M.D., William Greifinger, M.D., George F. Stoll, M.D., Michael J. O'Grady, M.D., and Nelson Manowitz, M.D., Clara Maass Memorial Hospital, Belleville

1. To show the results of gastric freezing in the treatment of duodenal ulcer;
2. The formation of a Committee in a general hospital with the regulation of such treatment on a scientific basis;
3. Explanation of the treatment to other physicians.

Booth S-239. Diabetes Detection Utilizing Automated Equipment—Arthur Krosnick, M.D., Coordinator, Diabetes Control Program, New Jersey State Department of Health, Trenton

The exhibit will show the feasibility of mass diabetes screening programs utilizing automated chemical analysis. Automated equipment will be operated continuously by a technician. Trained personnel will draw venous blood samples without charge to physicians. Methodology will be explained.

Technical Exhibits

Exhibit Hours:

9:00 a.m. - 5:00 p.m., Monday and Tuesday, May 13 and 14, 1963
9:00 a.m. - 1:00 p.m., Wednesday, May 15, 1963

Abbott Laboratories **Booth 39**

Abbott Laboratories' representatives will be happy to answer any question you may have concerning our leading products and new developments.

American Mutual Liability Insurance Co. **Booth 10**

To be of service to all members of The Medical Society of New Jersey, Joseph Britton and Paul Stanton will be available to answer any questions or discuss any problems relating to Professional Liability or Professional Premises Liability coverages. Medicolegal consent forms with legal digests will be available for those physicians not insured under the Official Loss Control Program, as underwritten by the American Mutual.

Ayerst Laboratories **Booth 18**

Ayerst Laboratories will be featuring *Thiosulfil*, *Riopan*, and *Plegine*. Our representatives will be on hand to discuss with you these products and any information you might desire on our other products.

Baby Service Inc. **Booth 51**

Visit the Baby Service booth. For the twelfth consecutive year there will be red roses for the ladies. The latest in professional diaper service improvements will be displayed and explained. Whether it is diaper service for the individual or for the hospital, Baby Service offers the finest.

The Baker Laboratories, Inc. **Booth 50**

Visit our booth where Baker's Modified Milk and Varamel, two successful products for infant feeding are on display. Baker representatives will be glad to discuss the benefits of Baker Milk products which provide all the normal dietary requirements plus a reserve for stress situations.

E. & W. Blanksteen **Booth 6**

Information and literature are available at this booth regarding The Medical Society of New Jersey's officially approved plans of disability, major medical, and life insurance.

The Borden Company **Booth A**

Borden's dermatologicals, unique amino acid therapy (reported to stimulate growth of epithelial tissue) in water washable, antiseptic creams. *Methakote*, *Methatar*, *Methaphor* and *Methaseptic*. Infant formulas *Bremil* and *Mull-Soy*. New data on milk allergy concerning the use of *Mull-Soy*.

Burroughs Wellcome & Co. (U.S.A.) Inc. **Booth 47**

Visit Burroughs Wellcome & Co. (U.S.A.) Inc. for the latest information on our products and the newest developments from the extensive research facilities of Burroughs Wellcome & Co. Of particular interest at this meeting will be *Cardilate* for angina, *Actifed* for allergic rhinitis, and *Mautadil Cream* for pruritus.

Cameron-Miller Surgical Instruments Company **Booth 53**

For almost fifty years Cameron has led the field in the production of the world's finest electrically lighted and electrically operated surgical instruments. Cameron recently merged with another large concern making similar instruments—The Miller Surgical Instruments Company of Chicago. This merger now represents combined patents and utilities of two great companies, making possible even better service to the doctors and hospitals throughout the world. Better lighted instruments or electro-surgical units cannot be made. They cost a little more.

Carnrick Laboratories **Booth 60**

Midrin, for the treatment of migraine and tension headaches, will be featured by Carnrick Laboratories. *Midrin* combines the cerebrovasoconstrictive action of isometheptene mucate with the relaxant-analgesic effect of dichloralphenazone and *Apap*. The action of *Midrin* is similar to that of ergotamine tartrate, but without the toxic side effects often encountered with ergotamine therapy. For this reason, *Midrin* can be prescribed routinely in the treatment of vascular headache.

Ciba Pharmaceutical Company **Booth 28**

Doriden is a nonbarbiturate sedative for nighttime, daytime, and pre-operative sedation. Side effects are minimal. *Doriden* rarely, if ever, causes respiratory depression; it has no toxic effects on the liver, kidney and blood. *Doriden* is well tolerated.

The Coca-Cola Company **Booth 40**

Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company of South Jersey, and The Coca-Cola Company.

Desitin Chemical Company, Inc. **Booth 29**

Desitin Ointment—for treatment of burns, ulcers, diaper rash, abrasions, etc. *Desitin Powder*—relieves chafing, sunburn, diaper rash, etc. *Desitin Suppositories* and *Rectal Ointment*—relieve pain and itching in uncomplicated hemorrhoids, fissures. No anesthetics or styptics. *Desitin Baby Lotion*—protective, antiseptic. *Desitin Acne Cream*—a non-staining, flesh-tinted *Medicream* for the treatment of acne vulgaris. *Desitin Cosmetic* and *Nursery Soap*—supermild. *Desitin Suppositories* with *Hydrocortisone*—prompt response to inflammatory conditions in proctitis, severe pruritus, edema. *Desitin Ointment with Hydrocortisone*—Hydrocortisone 1% and ¼% (as the alcohol) added to the well-known Desitin formula of Norwegian cod liver oil. *Desitin Hydrocortisone Cream*—non-staining, washable hydrophilic base with sol. al. acetate. An elegant cosmetic preparation with HC 1% and ¼%. *Desitin Cor-D-Tar Cream*—hydrophilic base with a special solution coal tar 3%, non-staining diiodohydroxyquin 2% and hydrocortisone 1% and ¼%. For bacterial-fungal-infectious eczematous discomfort.

The Dietene Company **Booth 34**

Have you tasted *Meritene? Meritene* is the good-tasting protein-vitamin-mineral food supplement prescribed to provide concentrated nutrition for patients with poor appetite or tolerance for ordinary food. Visit our booth and let us serve you a cool, refreshing *Meritene* nourishment. While there, review also our *Dietene Reducing Plan*, designed to get better cooperation from over-weight patients. The *Dietene Plan* provides optimum nutrition and maximum satiety without the use of drugs. *Meritene* and *Dietene* are advertised only to the medical profession.

Dome Chemicals, Inc. **Booth 52**

Dome Chemicals Incorporated, leader in dermatologicals, will feature dermatological specialties that are of general interest to the members of The Medical Society of New Jersey. Topical steroid products as *Cort-Dome*®, *Neo-Cort-Dome*®, *Dome-form-HC*®, *Lida-Mantle-HC*®, and *Cor-Tar-Quin* TM, will be presented. Our representatives will be available to discuss with you several products recently released from the research laboratories of Dome Chemicals.

Eaton Laboratories **Booth 36**

Since 1939, Eaton Laboratories has pioneered in the development of the nitrofurans, many of which have been available, as legend drugs, to the profession. Basic and clinical research is continuing on these, as well as other classes of compounds. In addition, Eaton Laboratories offers a variety of research and educational services for all phases of medicine. Our medical service representatives welcome the opportunity to furnish you with complete information covering these services and the nitrofurans.

Thomas A. Edison Industries **Booth 5**

Edison Voicewriter—Dictation Center U.S.A.—will show a complete line of business recording equipment designed to speed handling of medical paper work. Highlights: Edison Voicewriter ME models—full-featured dictating instruments for individual use by doctors in the office and at home. Edison Escort—battery-operated, portable dictating instrument. Edison Envoy—budget-priced magnetic recorded-transcriber. Televoice—phone network dictating systems for accurate, complete medical records in the hospital or clinic.

E. Fougera and Company, Inc. **Booth 58**

Product information and clinical literature, together with physician office aids, applicable in many areas of practice, will be offered. Clinical trial material will also be available or will be sent to your office if you wish. Digitaline Nativelle®—the original digitoxin, Diasal®, salt-without sodium, Polysorb Hydrate®, for dry skin and Aveeno products, for a wide range of skin disorders, are some of the products which will be on hand.

Geigy Pharmaceuticals **Booth 62**

The Geigy exhibit features important new therapeutic developments in the management of cardiovascular disease, as well as current concepts in the control of inflammation; hypertension and edema; depression; obesity, and other disorders, which may be discussed with representatives in attendance.

Gerber Products Company **Booth 56**

New! Gerber *Modilac*—A complete formula for infants. Gently processed to conserve nutritional values, it has true milk color and flavor. Modilac *is* milk adapted to the infant's physiologic requirements by the addition of a selected carbohydrate, replacement of butterfat with corn oil and supplementation with needed vitamins. Ask for complete information.

Health Insurance Council **Booth B**

The Health Insurance Council serves, on behalf of the Nation's insurance companies, as a central source of information and counsel to physicians, hospitals, and others in the health care field on all aspects of health insurance. The Council seeks to promote cooperation and understanding between those who provide health care and those who help finance its cost . . . to the end that the insurance business may provide the most effective and satisfactory health insurance protection possible.

Johnson & Johnson **Booth 1**

Johnson & Johnson will display the latest improvements in surgical dressings, as developed by the Johnson & Johnson Research Laboratories. Of special interest is *Surgicel Absorbable Hemostat*, a major advance in the control of hemorrhage which does not depend upon the normal clotting mechanism. *Dermicel Surgical Tape*, a newly-improved high strength special-purpose dressing tape for patients with unusual adhesive tape sensitivity, is an outstanding addition to the complete line of adhesive tape products. Other products, designed for your office, hospital or patient use, are also displayed. You will find well-informed representatives pleased to discuss these products or provide information on any other items made available by the world's largest manufacturer of surgical dressings and baby products.

Kessler Associates, Inc. **Booth 41**

A comprehensive display of prostheses and orthoses will be presented. The rehabilitation equipment displayed supplements our policy of complete services. Certified prosthetists will be present to suggest new component applications for your patients. Our research advancements indicate the application of external power to needs of the severly disabled. Explanation of recent developments will be made available by our certified personnel.

Knoll Pharmaceutical Company **Booth 59**

You may now prescribe fruit-flavored, taste-appealing *Quadrinal Suspension* for asthma patients who prefer a liquid to the time-proved *Quadrinal* Tablet. *Dilaudid* for pain that synthetic analgesics frequently fail to relieve; also for "the cough that must be controlled." *Metrazol*, Vita-*Metrazol* and *Nico-Metrazol* Elixir and Tablets for the geriatric and convalescent patient. *Akineton*, the new anti-parkinsonism agent.

Lamond Products, Inc. **Booth 13**

Lamond manufactures dermatological products exclusively. We shall feature a new product—*Aquol Bath Oil*—a superior lubricating and emollient oil additive to the bath for dry skins, eczema, pruritis and atopic dermatitis. We shall also display several of our other products: *Dermasorcin* (for acne), *Bur-Zin* (Burow's Emulsion), *Sebana Shampoo, Sebanator, Sunprotectol, Dermastringe* (skin cleanser), *Bur-Cort* (hydrocortisone topical cream), *Bentical Shake Lotion* (anti-pruritic, soothing lotion).

Lederle Laboratories **Booth 7**

Members and guests will be most cordially welcomed at the Lederle booth. Our medical representatives, who have access to the world-wide Lederle research organization, are prepared to furnish information regarding Lederle products and your related medical questions.

Lemmon Pharmacal Company **Booth 49**

Lemmon Pharmacal Company will be featuring our well-accepted products, Obestat Ty-Med and Neothylline®. Our professional service representatives will be there to welcome your questions on these and other useful Lemmon products.

Eli Lilly and Company **Booth 21**

The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

J. B. Lippincott Company **Booth 27**

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 150 years of traditionally significant publishing.

P. Lorillard Company **Booth 54**

At our booth, you will find a booklet on Lorillard's newest breakthrough in filtration research—the selective filtration of phenol from cigarette smoke. We fell sure you will find it interesting and informative. Lorillard is proud of this newest achievement and proud of the promise that you treat your taste kindly with Kent. As a remembrance of your visit, Lorillard will be pleased to give you a table cigarette box with your signature in gold, filled with either Kent or Newport cigarettes. Newport is the choice of menthol cigarette smokers. Please stop by and make your selection of this handsome souvenir.

Marshall Erdman and Associates **Booth 63**

Erdman Prefabricated Medical buildings are the result of years of experience in the field of design, manufacturing and construction. No other company has had as extensive experience in this field. Over 800 doctors are now practicing in Erdman-Built Buildings. Experienced architects, engineers and construction superintendents of the Erdman Company will design, manufacture and build your medical building from the land planning stage until you open the door into your own office. We assume responsibility for the entire job.

The S. E. Massengill Company, Inc. **Booth 3**

Visit our exhibit where Obedrin (tablets, capsules and new long-acting capsule) Strexate (the new muscle relaxant with built-in pain reliever) are featured. Our representatives will be pleased to discuss these and other Massengill products with you.

McNeil Laboratories, Inc. **Booth 23**

Visit our booth, where Mr. Al A. Hower is in charge. Products to be featured are: Butisol Sodium® butabarbital sodium, Butiserpazide®, Parafon Forte® and Tylenol® acetaminophen.

Mead Johnson Laboratories **Booth 57**

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

Medco Products, David Levinson, Distributor **Booth 17**

On display the latest in therapy equipment; *Medcolator, Medeo-Sonlator, Diapulse.* Also the *Kinemometer,* the 60-second thyroid function test with extremely high accuracy.

Medical-Surgical Plan of New Jersey **Booth 16**

Medical-Surgical Plan's exhibit portrays the outstanding growth and progress of the Plan during 1962, when new records were established for enrollment . . . amount of benefits paid in behalf of subscribers . . . number of physicians' and surgeons' services paid for . . . and number of Participating Physicians enrolled. An educational feature is the depiction of the many steps involved in processing a physician's claim. All members of the Society are cordially invited to visit the Plan's booth and receive an attractive souvenir.

Merck Sharp & Dohme **Booth 35**

The theme of the Merck Sharp & Dohme exhibit is "Service to Medicine." One phase features the details of the Merck Sharp & Dohme Postgraduate Program. Another feature includes information on teaching films for use by the profession, and also, lay films that can be utilized to portray the story of medicine to the lay public. The exhibit is concluded with a display of finger-tip files on selected Merck Sharp & Dohme products

Milex of Delaware Valley **Booth 14**

Our representatives will discuss new developments in the Milex Cancer Detection Program. A new concept in cervical therapy *Amino Cerv,* copies of "A Doctor's Marital Guide to Patients," "A Doctor Discusses Menopause" and "What Teenagers Want to Know," will be available upon request. New techniques in both office and operative gynecology will be reviewed.

Organon Inc. **Booth 45**

Of particular interest will be Hexadrol® (dexamethasone) one of the newer, most highly potent, well-tolerated and economical corticosteroids and Deca-Durabolin®—a safe, potent, long-acting anabolic stimulant indicated in a broad range of clinical conditions where tissue building is desired. Our professional service representatives welcome the opportunity to answer your questions concerning Hexadrol®, Deca-Durabolin® or any of our other products.

Ortho Pharmaceutical Corporation **Booth 37**

Ortho is proud to present a complete line of products for the control of conception. Featured will be the new *Ortho-Novum* Tablets, the oral product specifically designed for contraception. Also on display will be our well-known products for the treatment of all forms of vaginal infections. Representatives on hand will be pleased to answer any questions which you may have.

Pfizer Laboratories **Booth 20**

Visit the Pfizer Laboratories' booth where our professional service representatives will be pleased to discuss the latest topics of clinical interest.

Physicians' Planning Service Corp. **Booth 9**

Physicians' Planning Service Corporation is a national organization with offices in 19 principal cities. They are the group insurance administrators for the National Association of Residents and Interns. P.P.S.C. also offers to the established physician the *Lifeguard* Accident & Health Plan, including lifetime disability benefits—6 months waiting period, no reduction in benefits. Deferred payment life insurance is also available—deferring premium payments for the first 5 years.

Riker Laboratories, Inc. **Booth 38**

Representatives of Riker Laboratories, Inc. will be glad to supply you with complete information concerning our products which are available to the medical profession.

A. H. Robins Company, Inc. **Booth 46**

The A. H. Robins Company representatives will be happy to answer any questions you may have about our products and explain their advantages.

Roche Laboratories **Booth 8**

Librium—a therapeutic agent for superior, safer, faster control of nervousness, anxiety, tension and other common emotional disturbances without the dulling effect or depressant action of the tranquilizers.

J. B. Roerig and Company **Booth 24**

Representatives of J. B. Roerig and Company will be in attendance to answer any questions concering their exhibit of leading specialties and new products. Roerig recently introduced a number of

new products which representatives will describe and give information on the results of clinical reports.

William H. Rorer, Inc. **Booth 11**

Ananase Tablets—a new oral fibrin-depolymerizing (Proteolytic) enzyme from vegetable origin. *Maalox*—a pleasant-tasting non-constipating anacid in Suspension, Tablets No. 1 and Tablets No. 2. Representatives will gladly answer questions concerning Rorer products.

Sandoz Pharmaceuticals **Booth 31**

Visit our display where we are featuring Sansert, Mellaril Cafergot P-B and Bellergal. Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

W. B. Saunders Company **Booth 33**

New Saunders books published since last year's meeting include: Current Therapy 1963; Todd-Sanford's Clinical Diagnosis by Laboratory Methods by Davidsohn and Wells; Parsons and Sommers: Textbook of Gynecology; Bockus: Gastroenterology; and Bland: Metabolism of Body Water and Electrolytes.

Schering Corporation **Booth 2**

Visit the Schering technical exhibit where the following products will be featured: *Celestone®*, most active corticosteroid available; *Fulvicin-U/F®*, the new form of the oral antibiotic, Fulvicin, that halves the dosage requirement in most cases of ringworm; and *Chlor-Trimeton®*, unsurpassed antihistamine.

G. D. Searle & Co. **Booth 15**

Visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Smith Kline & French Laboratories **Booth 22**

May we discuss the use of SK&F products in your specialty? Our representatives, Mr. W. A. Tirsbier and Mr. R. E. McManigle, are on duty to answer specific questions you may have. Also, information on SK&F medical films and other special services is available on request. Products on display are: Cytomel®, Eskatrol®, Parnate®, and Teldrin®.

South Jersey Surgical Supply Co. **Booth 48**

South Jersey Surgical will exhibit for the first time, the brand new Med-Assist All Electric Physicians' Examining Table, as well as the brand new Model "75" Ritter Table. Also, see at this exhibit, the complete Hamilton Wall Hung Modular Examining Room in Walnut and White Formica. Talk to the South Jersey Surgical representative about our free Office Planning service.

E. R. Squibb & Sons **Booth 12**

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the medical profession in new products or improvements in products already marketed. We will be pleased to present up-to-date information on these advances for your consideration.

William Allen Steadman & Company **Booth 42**

William Allen Steadman & Company are the originators of complete financial service to the medical profession. This company is the investment adviser and the underwriter for Steadman Investment, Inc. It is also the underwriter for Professional Service, Inc. These companies were organized at the request of a group of New Jersey physicians in order to provide financial and investment assistance from internship through retirement.

George Tiemann & Co. **Booth 61**

George Tiemann and Company, a name synonymous with quality instruments for over 135 years, will display fine surgical instruments and associated medical items. Information regarding our repair service will be available upon request.

S. J. Tutag & Company **Booth 4**

S. J. Tutag & Company will exhibit *Cydril*, and *Cydril with Tuloidin*. Both of these products are indicated in the management of obesity, and are particularly noted for their appetite depressant activity with practically no central nervous system stimulation. Tutag representatives will look forward to discussing these products, as well as other products, in their complete obesity line, with you.

U.S. Vitamin and Pharmaceutical Corporation **Booth 30**

Arlidin—unique vasodilator—vasorelaxant will be on display. Increases blood flow to ischemic areas of brain, eye, inner ear, and the extremities. *Arlidin* provides sustained relief of pain, ache, spasm, intermittent claudication. Indicated in arteriosclerosis obliterans, thromboangiitis obliterans, diabetic atheromatosis, night leg cramps, ischemic ulcers, Raynaud's syndrome, thrombophlebitis, cold feet, legs and hands. Product brochures and other pertinent literature will be available.

The Upjohn Company **Booth 32**

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products

of Upjohn research that are designed to assist you in the practice of your professions. We solicit your inquiries and comments.

W-T-S Pharmaceuticals **Booth 43**

Desnex: Most widely prescribed fungicide used in the prevention and treatment of athlete's foot and other superficial fungus infections of the skin. *Caldesene*: Provides a lubricating and emollient film which is effective in the prevention or treatment of diaper rash and minor skin irritations.

Wallace Laboratories **Booth 44**

Information on *Capla*, a new kind of drug for the treatment of hypertension, will be featured. *Capla* acts specifically on the brain centers that control blood pressure, rather than indirectly or peripherally, like older antihypertensives. It has proved non-toxic in clinical use, and side effects are limited to occasional cases of drowsiness, usually transient in nature.

Warner-Chilcott Laboratories **Booth 55**

Papase®—the first anti-inflammatory enzyme of plant origin with clinical efficacy consistently demonstrated in double-blind studies, speeds up the normal physiologic processes of healing whenever inflammation and edema are part of the clinical picture. The unique trioral tablet may be chewed, swallowed or taken buccally with equal therapeutic effectiveness. *Peritrate*®—for the patient with coronary artery disease—with or without angina. Peritrate increases myocardial blood flow and oxygen supply safely—with no significant change in blood pressure, cardiac output or pulse rate.

The Warren-Teed Products Company **Booth 25**

Chymolase—an aqueous sterile solution of Chymotrypsin (5000 W-T units per c.c. and 50 mg. gelatin per c.c.) for relief of local inflammation and/or edema. *Kaon*®—an extremely palatable oral potassium.

Westwood Pharmaceuticals **Booth 26**

Westwood invites physicians to discuss their unique dermatological products: *Fostex Cream; Fostex Cake; Lowila Emollient; Lowila Cake; Sebulex; Fostril; Alpha-Keri.* These products are particularly suitable for personal use by physicians and their families who may be plagued with dandruff, acne, dry and itchy skin, and sensitivities to soap. Register, so that we may send prescription units to your home.

White Laboratories, Inc. **Booth 19**

White Laboratories products to be featured at this meeting are the White Otic Preparations—Otobione and Otobiotic. Medical service representatives will be pleased to discuss the broad range of indications for which these products provide effective therapy.

Golden Merit Award Ceremony

Saturday Afternoon, May 11, 1963

3:30 p.m.

The Golden Merit Award, established in 1957, is conferred upon every member of the Medical Society of New Jersey who has held the degree of Doctor of Medicine for fifty years.

Presiding

Louis S. Wegryn, M.D., President

Master of Ceremonies

John F. Kustrup, M.D., Chairman, Council on Public Relations

Marshals

Presidents of component societies whose members are receiving awards.

4:00 p.m.

Reception for Award Recipients and Their Families

Courtesy of the Committee on Annual Meeting

36th Annual Meeting
Woman's Auxiliary
to The Medical Society of New Jersey

HADDON HALL

May 11 - 15, 1963

Mrs. Samuel Kaman, Chairman
Mrs. Hugh Kearney, Co-Chairman

Daily Schedule

Saturday, May 11, 1963

10:00 a.m. to 5:00 p.m.—Sale of Dinner-Dance Tickets, MSNJ Registration Desk, Lounge floor

3:30 p.m. to 4:00 p.m.—Golden Merit Award Ceremony, West Room, Tower floor

Sunday, May 12, 1963

10:00 a.m. to 5:00 p.m.—Sale of Dinner-Dance Tickets, MSNJ Registration Desk, Lounge floor

12 noon to 4:30 p.m.—Registration, Lobby floor
Tickets on sale, Lobby floor for:
Tuesday—Annual President's Luncheon
(All doctors' wives invited)
Wednesday—Inaugural Luncheon
Art Exhibit, County Activities Pictorial Exhibit, and County Press and Publicity Books, Lobby floor

Monday, May 13, 1963

9:00 a.m. to 4:30 p.m.—Registration Lobby floor
Tickets on sale, Lobby floor, for:
Tuesday—Annual President's Luncheon
(All doctors' wives invited)
Wednesday—Inaugural Luncheon
Exhibits—Lobby floor

9:00 a.m. to 5:00 p.m.—Sale of Dinner-Dance Tickets, MSNJ Registration Desk, Lounge floor

10:00 a.m.—Pre-Convention Executive Board Meeting, West Room, Tower floor

12:30 p.m.—Fellowettes' Luncheon, Derbyshire Room, First floor (by invitation)

3:30 p.m.—Tea and Fashion Show — by Needle Craft Shop of the Boardwalk, West Room, Tower floor

7:00 p.m.—Dinner-Dance, Carolina Room, Lounge floor, Chalfonte

Tuesday, May 14, 1963

9:00 a.m. to 10:00 a.m.—Coffee and Sweet Rolls will be served, Wedgwood II, Lounge floor

9:00 a.m. to 12 noon—Registration, Lobby floor
Tickets on sale, Lobby floor, for:
Tuesday—Annual President's Luncheon
(All doctors' wives invited)
Wednesday—Inaugural Luncheon
Exhibits, Lobby floor

9:00 a.m.—General Session, Wedgwood II, Lounge floor

12:00 noon to 4:30 p.m.—Registration, Room 134, First floor
Sale of Luncheon Tickets, Room 134, First floor
Wednesday—Inaugural Luncheon
Exhibits, Room 134, First floor

12:30 p.m.—Annual President's Luncheon, West Room, Tower floor

2:00 p.m.—General Session Reconvenes, West Room, Tower floor

Wednesday, May 15, 1963

9:30 a.m. to 10:30 a.m.—Coffee and Sweet Rolls will be served, Rutland Room, First floor

9:00 a.m. to 12:00 noon—Registration, Room 134, First floor

10:30 a.m.—Post-Convention Executive Board Meeting, Derbyshire Room, First floor

12:30 p.m.—Inaugural Luncheon, Rutland Room, First floor

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

APRIL, 1963 • VOL. XXXVI, NO. 4

PNEUMONECTOMY AND LOBECTOMY IN BRONCHOGENIC CARCINOMA

In a comparative study of 5-year survival rates of patients treated for carcinoma by removal of the entire lung and others by the excision of the affected lobe only, it was found that the more radical operation did not increase the chance of survival.

Since a systematic analytical comparison of available data on the treatment of bronchogenic carcinoma by pneumonectomy and by lobectomy was desirable, Dr. Alton Ochsner of New Orleans, who has consistently espoused pneumonectomy for lung cancer, and Dr. Richard H. Overholt of Boston, who in recent years has tended to use lobectomy as the treatment of choice agreed to permit the Biometry Branch of the National Cancer Institute to compare the survival of their surgically treated patients.

The study group from the Overholt Clinic consisted of 327 surgically-treated patients with carcinoma of the lung diagnosed during 1951-1956. Of these, 211 were pneumonectomies and 116 were lobectomies. X-ray treatment was limited to 19 per cent of the pneumonectomies and 6 per cent of the lobectomies. Only two patients received adjuvant chemotherapy (nitrogen mustard) following pneumonectomy as part of the primary treatment, and one patient received both x-ray and chemotherapy following lobectomy.

The study group from the Ochsner Clinic consisted of 205 patients who were subjected to resection during 1948-1956. All but 15 had pneumonectomies. The standard procedure is the removal of the entire involved lung with an en bloc excision of the mediastinal nodes. At this clinic 65 per cent of the patients who underwent a pneumonectomy received no adjuvant therapy. In 35 per cent, the primary treatment included the addition of x-ray therapy (3 per cent), chemotherapy with nitrogen mustard (27 per cent), or both (5 per cent).

THREE GROUPS OF PATIENTS

There were, therefore, three main groups of patients treated surgically for primary lung cancer: (1) Overholt pneumonectomies, 211 patients, of whom 122 (58 per cent) had mediastinal lymph node dissection; (2) Overholt lobectomies, 116 patients, of whom 41 (35 per cent) had mediastinal lymph node resection as the exposure allowed; and (3) Ochsner pneumonectomies, 191 patients, of whom 181 (95 per cent) had mediastinal lymph node dissection, usually en bloc with the lung.

The 5-year survival rate was definitely higher for patients treated by the Overholt lobectomy (27 per cent) than for patients treated by pneumonectomy (19 per cent at the Overholt Clinic and 15 per cent for the Ochsner Clinic).

The single most important determinant of prognosis is probably the anatomical extent of involvement. The three groups of patients analyzed were classified as "localized" cases, i.e., those in which the tumor was confined to the

M. B. SHIMKIN, M.D.; R. R. CONNELLY, B.S.; S. C. MARCUS, B.S.; and S. J. CUTLER, SC.D. *The Journal of Thoracic and Cardiovascular Surgery*, October, 1962.

lung or bronchus and in which no direct extension to neighboring tissues or metastasis was found, and "not localized," i.e., those in which there were regional lymph node metastases or extension of the tumor beyond the lung.

The proportion of the more favorable, localized cases is highest in the Overholt lobectomy group, 52 per cent in contrast with 21 and 26 per cent in the Overholt and Ochsner pneumonectomy groups, respectively. Thus, a major factor in the better survival following lobectomy is the greater proportion of patients with localized tumors selected for lobectomy.

LOCALIZED TUMORS

Among localized cases, the observed 5-year survival rates for the three operation groups were practically identical. Among non-localized cases, the survival rate was significantly lower following the Ochsner pneumonectomy than for Overholt patients treated by pneumonectomy; the results following the Overholt lobectomy were not significantly different from either pneumonectomy group.

The clinical significance of these observations is difficult to evaluate since the considerations which led to the use of more extensive surgery in some cases and less in others are not fully known. However, the available evidence suggests that less extensive surgical procedures are related to survival rates that are at least as good as, and perhaps better than those recorded following more extensive surgery.

The data from the Overholt and the Ochsner clinics were compared with similar data from 99 hospitals in the United States on more than 8,800 cases, as reported by the End Results Group of the National Cancer Institute. The end results are similar and emphasize the universally grim prognosis of this neoplastic disease.

The 5-year survival of approximately 8 per cent among all patients with bronchogenic carcinoma seen at the two clinics compares with 6 per cent in the 99 hospitals. This small salvage is achieved only by surgical resection.

The available data lead to the following conclusions:

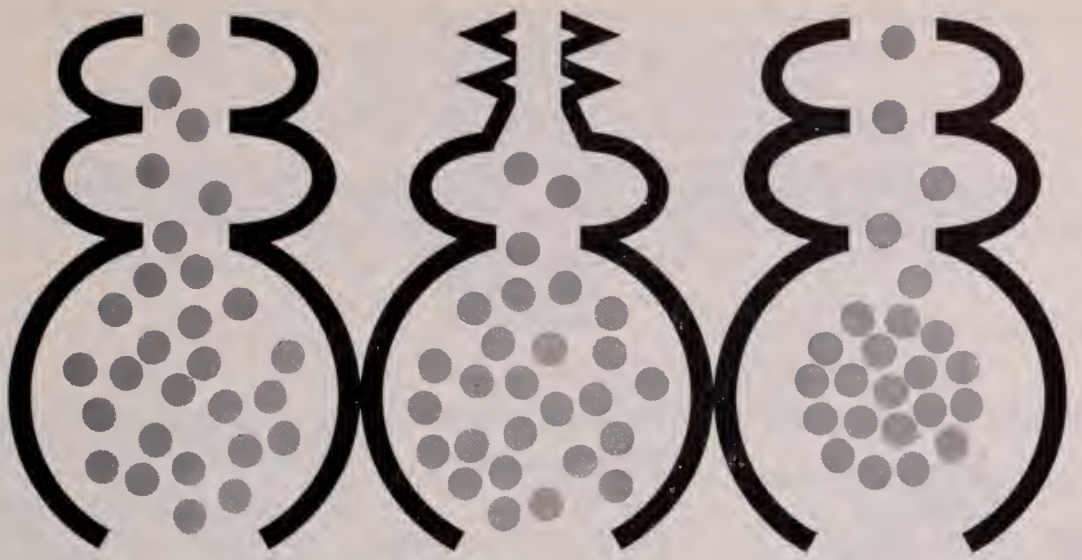
1. Survival after surgical resection was primarily determined on whether the tumor was localized or had extended to lymph nodes or contiguous tissues beyond the lung.
2. Survival in patients with localized lung cancer was similar whether lobectomy or pneumonectomy was performed. The available evidence does not clearly delineate the efficacy of lymph node dissection.
3. Survival of patients with non-localized carcinomas was lower following pneumonectomy with mediastinal lymph node dissection than after more limited pneumonectomy or lobectomy.
4. Survival in these series was not demonstrably improved by the addition of x-ray therapy or chemotherapy with an alkylating agent.
5. Tumors classified as being histologically undifferentiated had a graver prognosis than the epidermoid neoplasms or the adenocarcinomas.
6. Survival was not demonstrably related to the size of the primary tumor, the site of the primary tumor within the lung, or the age and sex of the patient.

In regard to Point 3 it may be said that the less extensive operations do not save more patients, but the more extensive operations increase mortality.

The tragic limitations of effective treatment of bronchogenic carcinoma, and the established causation of an important proportion of this neoplasm by cigarette smoking, make the disease a challenge to preventive medicine as well as to cancer research.

New Jersey Tuberculosis and Health Association

15 East Kinney Street, Newark 2, New Jersey



lowers motility | relieves cramping | stops diarrhea

LOMOTIL® Antidiarrheal tablets and liquid

(brand of diphenoxylate hydrochloride with atropine sulfate)

Traditionally the most effective means of slowing excess intestinal motility in diarrhea and so of relieving the disorder have been the opium derivatives. Now Lomotil makes available an antidiarrheal agent[1] of greater therapeutic efficiency than morphine.

By controlling hypermotility, the basic mechanical dysfunction of diarrhea, Lomotil reduces the frequency and fluidity of stools, diminishes cramping and controls diarrhea in many patients in whom other drugs have proved inadequate.

In a recent clinical report Cayer and Sohmer[2] state: "The alleviation of symptoms [with Lomotil] was usually prompt, occurring within 24 to 72 hours even in the long-standing chronic cases. . . . A surprisingly satisfactory response was obtained in 75 per cent of the patients with regional enteritis and in 63 per cent of those with ulcerative colitis, all of whom had failed to respond to other measures."

The high therapeutic efficiency of Lomotil, its safety, convenience and economy may be used to advantage in acute or chronic diarrhea.

Dosage: For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily. Maintenance dosage may be as low as two tablets daily.

Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. Recommended dosage schedules should not be exceeded.

Note: Lomotil is an exempt preparation under Federal narcotic statutes.

Detailed information and directions for use in children and adults are available in Physicians' Product Brochure No. 81. G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

1. Janssen, P. A. J., and Jageneau, A. H.: A New Series of Potent Analgesics: Dextro 2:2-Diphenyl-3-Methyl-4-Morpholino-Butyrylpyrrolidine and Related Amides. 1. Chemical Structure and Pharmacological Activity, J. Pharm. Pharmacol. 9:381-400 (June) 1957.
2. Cayer, D., and Sohmer, M. F.: Long-Term Clinical Studies with a New Constipating Drug, Diphenoxylate Hydrochloride, N. Carolina Med. J. 22:600-604 (Dec.) 1961.

G. D. SEARLE & CO. *Research in the Service of Medicine*

BROADLOOM CARPETS — ORIENTAL RUGS
Rugs Washed, Repaired and Stored
B. SHEHADI & SONS, Inc.
CHATHAM
400 Main Street — MErcury 5-8100
EAST ORANGE
51 Central Ave. — ORange 3-5382

THE FIRST NATIONAL BANK of North Bergen
"An Accommodating Bank in a Progressive Community"
4300 BERGEN TURNPIKE NORTH BERGEN, N. J.
Member of Federal Reserve System and Federal Deposit Insurance Corporation



PROFESSIONAL MEN
DESERVE
PROFESSIONAL SERVICE !
FOR YOUR ESTATE PLAN —
We urge you to consult with one of our Trust Officers
TRENTON TRUST COMPANY
MARY G. ROEBLING, President
28 West State Street
Trenton, N. J.
MEMBER FEDERAL DEPOSIT INSURANCE CORPORATION



You know the advantages of specialization . . .
let skilled professionals protect your estate!
We coordinate our efforts with your attorney, insurance agent and accountant. New Jersey Bank Trust Dept.: Passaic, GR 3-5600; Paterson, MU 4-3300.

NEW JERSEY BANK AND TRUST COMPANY
Member Federal Deposit Insurance Corp.
Member Federal Reserve System

THE Millville National BANK



BANK BY THE CLOCK — COR. HIGH & MAIN

SINCE 1857
A FINANCIAL STRONGHOLD

A SAFE
CORNER TO BANK ON

MEMBER FEDERAL DEPOSIT INSURANCE CORPORATION

Doctors Are Busy People!

To save time and avoid wasted effort,
do all your banking at

1ST NATIONAL BANK
AND TRUST COMPANY OF PATERSON

CONVENIENT OFFICES IN . . .
PATERSON • BLOOMINGDALE • CLIFTON • MOUNTAIN VIEW •
POMPTON LAKES • PREAKNESS • RINGWOOD • BOROUGH of TOTOWA
• WANAQUE BOROUGH • WEST MILFORD, New Jersey

MEMBER FEDERAL DEPOSIT INSURANCE CORPORATION

1766 - 1963

197 YEARS OF SERVICE TO THE PEOPLE OF THE STATE OF NEW JERSEY

Congratulations to . . . . . .

THE MEDICAL SOCIETY OF NEW JERSEY

on the occasion of their

ONE HUNDRED NINETY-SEVENTH ANNUAL MEETING

The First National
IRON BANK

MORRISTOWN • ROCKAWAY • ROCKAWAY TOWNSHIP
MOUNTAIN LAKES

MEMBER OF FEDERAL DEPOSIT INSURANCE CORPORATION

We cordially invite you to bank with us

1st TRENTON NATIONAL BANK

1st IN SERVICE IN DEPOSITORS IN SIZE
in Central New Jersey

OVER TWENTY YEARS of significant success collecting New Jersey Medical Accounts. A dignified Collection Service that gives each item, be it large or small, the same diligent, conscientious efforts of our trained and experienced staff.

A Listing Form will be sent on request

Madison Credit Bureau
INC.
220 Fifth Avenue New York 1, N. Y.

YOUR SAVINGS EARN MORE AT THIS MUTUAL SAVINGS BANK

CURRENT DIVIDEND **4%** per annum

HUDSON CITY SAVINGS BANK

Jersey City Offices:

Main Office:
587 Summit Avenue at 5 Corners

Bayview Branch:
532 Ocean Avenue at Bayview Avenue

Boulevard Branch:
2530 Hudson Boulevard at Jewett Avenue

North Bergen Branch:
7533 Bergenline Ave., North Bergen

Deposits Insured up to $10,000
By Federal Deposit Insurance Corporation



. . . For You!

Dosage:
A lot or a little as patient can afford. (Dollars Saved)

Frequency:
Regularity is important — once each week or each month.

Benefits:
Future security, peace of mind, achieved quickly with regular earnings on insured savings at . . .

Boiling Springs
Savings and Loan Association

23 PARK AVENUE
Rutherford, N. J.

615 RIDGE ROAD
Lyndhurst, N. J.

Congratulations . . .

to The Medical Society of New Jersey for the excellent and professional service you have rendered to the people of New Jersey for so many years.

We particularly want to express our appreciation and thanks to those members who have contributed so greatly to the sales success of our field organization during the past year. Our sincere gratitude to you for a job well done!

Bankers National Life
INSURANCE COMPANY
MONTCLAIR, NEW JERSEY
(201) 744-8000
LIFE — HEALTH — GROUP INSURANCE

WE render a complete decorator service, at no charge or obligation.

New Jersey's largest distributor of prominent name brands of wood and steel **Office** and **Reception Room Furniture.**

Custom-Made upholstered Furniture in our own plant, at professional discount.

Business Furniture, Inc.
542 North Ave. Elizabeth, N. J.
EL. 5-3400
BENJAMIN KLAUSNER, President

SCUDDER, STEVENS & CLARK COMMON STOCK FUND, INC.

A mutual fund providing an investment in carefully selected common stocks.

This fund is offered at net asset value with no sales charge.

. . . . . .

Scudder Fund Distributors, Inc.
320 Park Avenue, New York 22, N. Y.
or
Ten Post Office Square, Boston 9, Mass.

Please send information concerning the Scudder, Stevens & Clark Common Stock Fund, Inc.

name . . . . . .

address . . . . . .

city . . . . . .

zone . . . . state . . . . . .

GREETINGS FROM

NATIONWIDE INSURANCE COMPANIES

AUTO - FIRE - LIFE - ACCIDENT AND SICKNESS - WORKMEN'S COMPENSATION
GENERAL LIABILITY

Regional Office:
2303 BRUNSWICK AVENUE
TRENTON, NEW JERSEY

Home Office:
246 N. HIGH STREET
COLUMBUS, OHIO

ROMA SAVINGS AND LOAN ASS'N.

485 HAMILTON AVENUE
Trenton 9, New Jersey

INSURED SAVINGS

Phone: LY 9-9301

HEALTH ★ INSURANCE ★ COUNCIL

You are cordially invited to visit the Health Insurance Council **Coffee Lounge** during the 197th Annual Meeting of The Medical Society of New Jersey . . . the Garden Room — Scientific Exhibit Area, Haddon Hall, Atlantic City, May 11 - 15, 1963.

Health Insurance Council

REPRESENTING THE NATION'S INSURANCE COMPANIES

The New Jersey State Committee . . .

. . . of the Health Insurance Council is the central point of contact for New Jersey physicians and hospitals. State Committee objectives are to—

- Resolve local problems of mutual concern.
- Exchange information on questions involving financing of health care costs.
- Provide through mutual cooperation better health care service for insured patients and their families.

PRESCRIPTION . . .
for a healthy financial future
save regularly at . . .

GUARDIAN Savings
AND LOAN ASSOCIATION

In Atlantic City
(Main Office)
1410 Atlantic Ave.

In Margate City
(Downbeach Office)
8003 Ventnor Ave.

SISCO DAIRY FARMS
New Jersey Produced
MILK AND MILK PRODUCTS
since 1896
66 Mt. Prospect Ave. Clifton, N. J.
Greg. 3-1500

"Deliciously Different"
DOLLY MADISON
ICE CREAM

FOREMOST ICE CREAM
— PRODUCTS OF —
Foremost Dairies, Inc.

THE BEST IN DAIRY PRODUCTS
Decker's DAIRY INC.
for deliveries call
TRENTON . . .
ask operator for WX-5070
HIGHTSTOWN . . .
dial 448-0106
PRINCETON . . .
ask operator for WX-5070

BECKER DAIRY FARMS
Becker
DAIRY FARMS
at Roseland, N. J.
Since 1860
"Exclusivley"
Grade "A" Dairy products
CApital 6-2000 ORange 5-5000

ENJOY LIFE — EAT OUT MORE OFTEN

DINERS CLUB

RESTAURANT
STOCKHOLM
FAMOUS FOR FOOD AND ATMOSPHERE

AMERICAN EXPRESS

SWEDISH SMÖRGÅSBORD
Luncheons — Weddings —Banquets — Dinners

ON ROUTE U. S. 22
MR. and MRS. NIELS LILJA, Owners

SOMERVILLE, NEW JERSEY
Tel. RAndolph 5-9898-2235

Raritan Valley Farms, Inc.

QUALITY DAIRY PRODUCTS
and
OLD FASHIONED ICE CREAM

•

STOP AT THE "MINUTEMAN"

RF

SOMERVILLE

RT. 206 RA. 5-0687

HOTEL ESSEX HOUSE
Broad Street at Lincoln Park
Newark, New Jersey
A. C. ALLAN, General Manager

•

Largest and Most Complete Catering, Banquet, Ballroom, and Meeting Facilities
All Function Rooms Air Conditioned

•

HOME OF
THE "CAROUSEL"
and
THE CHARCOAL CORNER

•

For inquiries and reservations
Telephone MItchell 2-4400

Blue Ribbon Dairy Farms

Country-Produced Milk

RETAIL WHOLESALE

2231 Morris Ave. Union, N. J.
MUrdock 6-1900

MILLSIDE FARMS
Producers of
HOMOGENIZED
Vitamin "D" Milk
FROM
GOLDEN GUERNSEY CATTLE
RIVERSIDE, NEW JERSEY
Phone Hobart 1-0046

Sailing Fun for the Whole Family

aboard the racy 11'

SEA SNARK $99.75*

*plus handling and freight

Completely rigged with **nylon sail,** weighs 30 lbs. — Unsinkable — Carry on any car or inside a station wagon. Over 11,000 sold. **Send check for $99.75** - we will ship immediately and pay freight.

Write for catalog to

SNARK PRODUCTS, INC.
P.O. Box 89
Ft. Lee, N. J.



CAPTAIN STARN'S

SEAFOOD
RESTAURANT & YACHT BAR
STEAKS and CHOPS

All Kinds of Yachting

CAPT. STARN and CAPT. SWANN, Mgrs.

Inlet — Atlantic City, N. J.
Phone 4-3905 Ample Parking

THE ORANGE PUBLISHING CO.

PRINTERS

116-118 LINCOLN AVENUE
Orange New Jersey

WONPOSET — *on beautiful BANTAM LAKE!*

LITCHFIELD, CONNECTICUT

58th year. 125 boys (5-15) — 4 age groups. All land and water sports. 45 boats. Crafts, Sailing, Water-Skiing, Baseball, Basketball, Riflery, Archery, Tutoring, Tennis, Riding, Jr. Program. Overnight trips. Experienced counselors. Infirmary. Good food. High return rate. 100 miles from New York City. Individual Swim Instruction. $495.00. Booklet
E. H. ANDERSON, 20 Wakefield Place., Caldwell, New Jersey **tel. CA. 6-5031**

SMORGASBORD LUNCHEON — Noon till Three

ZABERERS

PRIME RIBS

BLACK HORSE PIKE
Near Atlantic City Races
45 Minutes Phila. - Camden Area

WINDJAMMER VACATION

The three masted schooner VICTORY CHIMES, largest passenger windjammer under U. S. flag

Weekly cruises along the coast of Maine, sailing each Monday from Rockland, mid-June through mid-September. Comfortable staterooms — excellent food. Color folder.

Capt. Frederick B. Guild
MAINE COAST CRUISES
Box L, Rockland, Maine

John R. Cocco, Inc.

Certified Manufacturers and Fitters of

ORTHOPEDIC and **PROSTHETIC APPLIANCES**

- Functional Arm Bracing
- Functional Leg Bracing

333 CHAMBERS ST.
Trenton 9, N.J.
Phone: EXport 3-5939

COCCO BROS.
1223 S. 15th St.
Phila. 46, Pa.
Phone: DE. 4-3816

Male and Female Attendants

F. G. Hoffritz, Opticians

GUILDCRAFT OPTICIANS

Zenith Hearing Aids

30 PARK PLACE

Phone LO. 8-7628 **ENGLEWOOD, N. J.**

MAGER & GOUGELMAN, Inc.

FOUNDED 1851

COMPLETE ARTIFICIAL EYE SERVICE

- **Evisceration Type and Cosmetic Contact Lenses**
- **Conformers and Drains**
- **Custom Made and Stock Eyes**
- **Glass and Plastic Eyes**
- **All Types of Motility Implants**

PHILADELPHIA, PA.
37 South 20th Street
Phone LOcust 7-7628

NEW YORK, N. Y.
120 E. 56th Street
Phone PLaza 5-3756

KESSLER ASSOCIATES, INC.

ORTHOTICS, Inc.

Certified Fitters and Facilities

ARTIFICIAL LIMBS **BRACES**

COMPLETE REHABILITATION EQUIPMENT

166 CLINTON AVENUE **NEWARK, NEW JERSEY**

Bigelow 2-5431



Vacancy

The direct cost for caring for the mentally ill is 1.7 billion a year. Workers who become mentally ill ose over half a billion dollars in earnings each year.

*taff in one mental hospital recently tried an xperiment with 65 patients who had been confined or an average of 13 years. They practiced the best reatment methods now known and, within six nonths to a year, 37 of these patients were well nough to be discharged. Only eight of the ischarged patients failed to hold the gains they had nade for at least a year after they left the hospital."**

Hope now, where there was no hope. Drugs which help now, where there were no known drugs which helped—even five years ago. Independent drug research is continuing in this vital area. But, should it be discontinued because the cost must somehow be reflected in the ultimate price of the new drug—if it is to be discovered? Or should the sign read, as it has throughout time in overcrowded mental institutions: "NO VACANCIES."

*U.S. Department of Health, Education and Welfare, Public Health Service Publication No. 813.

This message is brought to you on behalf of the producers of prescription products.

PHARMACEUTICAL MANUFACTURERS ASSOCIATION • 1411 K STREET, N.W. • WASHINGTON, D.C.

ABBOTT MANOR NURSING HOME

810 CENTRAL AVENUE - **PL. 7-0696** - **PLAINFIELD, N. J.**

24-HOUR NURSING SERVICE ELEVATOR SERVICE

ALICE ABBOTT, R.N. DORIS ABBOTT, R.N.

MRS. MARY J. BALL

BOARDING HOME FOR THE AGED

141 SO. BURNETT STREET ORange 3-4305 EAST ORANGE, N. J.

TEaneck 6-4112 Personal Physicians Welcome

BRIGHT SIDE NURSING HOME

TEANECK **NEW JERSEY**

PEARL WALLACE, R.N. Owner-Management JESSE WALLACE

New Modern Wing

A FAMILY HOME WITH PROFESSIONAL CARE

Elizabeth Manor Nursing Home

— AN IDEAL HOME FOR CHRONICS, CONVALESCENTS, AGED —

Licensed by the State of N. J. **Full Cooperation with Patient's Own Doctor** WE INVITE YOUR INSPECTION Member of Licensed Nursing Home Assoc. of N. J.

1048 GROVE STREET, ELIZABETH, N. J. **EL 4-0002**

The BRUNSWICK PARK Nursing Home, Inc.

SCHEDULED TO OPEN SPRING 1963



NEW MODERN LUXURIOUS RANCH TYPE

No Steps

Most Up-to-Date Equipment

- Referring physicians have full medical privileges
- Physical and recreational therapy program
- Experienced professional staff
- Special diets
- Audio-Visual Nurses' call system for every room
- Air-conditioned lobby, lounge and dining room
- Private & semi-private rooms
- Sanitary all-stainless steel kitchen, tiled to ceiling
- Tiled Wheel-In Showers and baths
- Piped-In music
- Spacious Outdoor Patios
- Reasonable rates
- Inspections invited

Intersection U.S. 1 and U.S. 18 opposite Howard Johnson's

Tel. 828-2400 **NEW BRUNSWICK, N. J.**

SUNLAWN
Nursing Home

ALL ASPECTS OF
TENDER, LOVING CARE
24 HOURS A DAY

* * *

If a Nursing Home has become a "must," come look us over, we're sure we have what you need!

DEAN and HELEN B. WILSON

576 NORTH MAIN STREET
Phone: 448-0528 HIGHTSTOWN, N. J.

Greetings

To the Members of
The Medical Society of
New Jersey

•

KATE MACY LADD
Convalescent Home

FAR HILLS, N. J.

A. L. VAN HORN, M.D., Medical Director

J. F. Dixon, Jr., M.D., Asst. Med. Director

J. E. Cumiskey, R.N. J. J. McGrady, R.N.

PINE ACRES NURSING HOME

51 MADISON AVENUE MADISON, NEW JERSEY

SYLVAN HOSPITAL and NURSING HOME

Trenton & Grand Avenues Box 146 West Trenton, N. J. TU 2-0236

MARTA VOL-TRETTER, M.D.
Medical Director
Member American Psychiatric Assoc.

W. J. HOLLENDONNER, M.D.
R. G. BARRY, M. D.
Fellow American Psychiatric Assoc.

ELEONORE La COUR, R.N.
Superintendent

For the Specialized Care and Treatment of
NERVOUS AND PSYCHOSOMATIC DISORDERS

THERAPIES AS INDICATED FOR THE INDIVIDUAL CASE:

• Insulin Biological • Electroshock • Pharmacotherapy • Psychotherapy

Accredited and Licensed (PMH 5) by N. J. Dept. of I. & A. Cooperating Hospital, Hospital Service Plan of N. J.

GREETINGS

NATIONAL X-RAY SURVEYS, Inc.

ORANGE NEW JERSEY

JEfferson 8-2117 State Approved

Hillside Rest Home

FOR RETIREMENT AND AGED

Good Food Nurse in Charge Reasonable Rates

G. & T. BRAIN TABOR ROAD, ROUTE 53 MORRIS PLAINS, N. J.

Ivy Hall Licensed Nursing Home

CARDIACS - INVALIDS - CONVALESCENTS - CHRONIC-AGED - DIABETICS - OBESITY

PARK ENTRANCE, BRIDGETON, NEW JERSEY

Benjamin Berkowitz, M.D., Medical Director Phone: GL. 1-2990

Telephone ORange 4-5848 Licensed

Llewellyn Nursing Home, Inc.

515 PARK AVENUE ORANGE, NEW JERSEY

MR. ANDREW KITCHELL, Adm.

CHRISTIAN SANATORIUM

301 SICOMAC AVENUE

WYCKOFF, N. J.

●

A NON- PROFIT,

120 BED INSTITUTION

FOR

MENTAL and NERVOUS

DISORDERS

OVER 50 YEARS OF SERVICE

MONTCALM

A Nursing Home of Distinction

Invites Your Inspection

32 PLEASANT AVENUE

MONTCLAIR, N. J.

Phone PIlgrim 4-4560

AMITY NURSING HOME

Ringoes, N. J.

●

Professional Nursing Care to the Aged and Chronically Ill

Mrs. K. Heck
Miss R. Reedy Flemington 1452-J4

MIDDLESEX NURSING HOME, Inc.

HIGHWAY 27, METUCHEN, N. J.

LIBERTY 9-1264

A 60 bed, well equipped and administered institution for the cardiac, the chronically ill, and the terminal case. Oxygen therapy, IV and SQ medication and fluid replacement. Clinical and ECG laboratory facilities. Registered Nurses around the clock. Institution's physicians on call for emergencies or for routine supervision when requested by family physician.

Vincent Scully, Administrator

DORETHY-HALL SCHOOL

Established 1909

A refined home school for exceptional girls. Limited to eight pupils. Individual care and instruction.

For booklet address:
Miss Mary E. Dorethy, *Director*

BELMAR NEW JERSEY

The Bancroft School & Camp

9 mos. Haddonfield, N J. 3 mos. Owl's Head, Me. 80 years of service to the retarded and/or emotionally unstable child. New facilities for comprehensive program in education, evaluation and vocational training. Community services include new rehabilitation center with services in diagnosis, evaluation, therapy and vocational training. Year-'round program. Comprehensive educational, medical and psychological services. Modern speech and hearing department. Social advantages.

Jenzia C. Cooley, Prin., Box 335, Haddonfield, N. J.

DOCTORS RECOMMEND

RANDY PEDICS
CANVAS FOOTWEAR

- 3 POINT SUSPENSION
- ARCH CUSHION
- STEEL SHANK
- REINFORCED COUNTER



Send for Free Literature Dept.

RANDOLPH SHOE CO., INC.
32 S. MAIN STREET · RANDOLPH, MASS.

Ricci's Shoes, Inc.

(Specialists in Prescription Shoe Fittings)

43 KINGS HIGHWAY, EAST
HADDONFIELD, NEW JERSEY

PHONE HA. 9-2243

CLAIRMONT CADILLAC

1 GREENWOOD AVENUE • MONTCLAIR, N. J.

Phone PIlgrim 4-0700

"Service is our Business"

BROGAN

Cadillac - Oldsmobile Company

PATERSON RIDGEWOOD

PASSAIC - CLIFTON

New Jersey's Largest Cadillac Distributor

WE ALSO LEASE!

"Our Compliments to Our Many Physician Friends"

KASSEL

CADILLAC COMPANY, Inc.

2214 HUDSON BOULEVARD UNION CITY, NEW JERSEY

UN. 5-1790 Distributors for Hudson County and Vicinity

Cadillac

by SCOTT SMITH CADILLAC CO.

PHILA. • ARDMORE • GERMANTOWN • CAMDEN

AMERICA'S LEADING CADILLAC DEALER

Central Cadillac

360 CENTRAL AVENUE, NEWARK • MA. 4-2255

GREETINGS FROM YOUR

Esso

DEALERS

You Don't Use
SECOND CLASS EQUIPMENT
In Your Practice . . .

Doctor, you know that nothing but the best will do in treating your patients. And you deserve to go first class — in your own airplane — when you relax. Many professional people, such as yourself, are finding pleasurable new excitement in the sky. They're getting away from the pressures of their practices by flying away on weekends and on vacations to such interesting places as Mexico, Canada, Bermuda. You've probably heard of the **"Flying Physicians,"** an organization composed exclusively of your colleagues who have already discovered the satisfaction of flying their own airplane. It's easy to fly and fun to own an airplane. If you can drive a car, you can probably learn to fly without difficulty. whether you are 25 or 55.

With 35 years of aviation experience behind us, ATLANTIC is proud to offer **BEECHCRAFT,** the finest line of private and business aircraft in the world. Start with the **MUSKETEER,** the "family car of the air." It's so easy to handle it almost flies itself.

If you are already flying your own aircraft, consider trading up to one of the larger, faster, even more comfortable models in the BEECH line, such as the **BONANZA,** the **TRAVEL AIR** or the **BARON.**

Call the nearest ATLANTIC branch listed below and talk it over. They'll be happy to answer all your questions and arrange a demonstration at your convenience.

Atlantic Aviation CORPORATION

• **PHILADELPHIA, Pa.**
International Airport
SAratoga 6-7500

• **WORCESTER, MASS.**
Worcester Municipal Airport
791-7321

• **WILMINGTON, DEL.**
Greater Wilmington Airport
EAst 8-6611

• **NEW YORK, N. Y.**
Teterboro Airport
ATlas 8-1740

• **LYNCHBURG, VA.**
Lynchburg Municipal Airport
239 - 2641

ADAMS & SICKLES
W. STATE and PROSPECT STS.
TRENTON, N. J.
24-HOUR PRESCRIPTION SERVICE
Physicians' Supplies
Hospital Supplies
Trenton—Owen 5-6396

PENNINGTON PHARMACY
L. SCHILDKRAUT, Prop.
COMPLETE STOCK
2 N. MAIN STREET
PENNINGTON, N. J.

JOSEPH PARENTINI'S Pharmacy, Inc.
Established 1903
CHARLES H. ARNOLDI, Ph.G.
1227 BERGENLINE AVE., Cor. 13th St. UNION CITY, N. J.
Delivery Service UNion 7-4806, 7-9411

GREETINGS
The Pharmacy of F. W. Schmid
TENAFLY

PRICE SUBJECT TO CHANGE WITHOUT NOTICE
5000 PRESCRIPTION BLANKS $10.00
PRINTED ON 16 lb. WHITE BOND PAPER ALSO ON 20 lb. 5000 — $12.00
QUICK SERVICE PRESS
BOX 92, NEW YORK 2, N.Y. TELEPHONE GE. 5-1103

Call Us for
CAPABLE ASSISTANTS
AND TECHNICIANS

TRAIN FOR A CAREER
Medical Office Assistant & Secretarial, Medical Laboratory Technology, X-Ray, Office Assisting
Manhattan Medical Assistants School
1780 BROADWAY, NEW YORK PL. 7-8275
Day and Evening Coed Courses State Licensed

— Greetings from . . .
CRISANTI SHOE HOSPITAL
CRANFORD, NEW JERSEY

CAstle 3-1949 **CHARLES W. ROGERS & SON, Inc.**
Curtis and Union Aves., Manasquan, N. J. Marine & Mobile Electronics Since 1926
NATION'S LARGEST DISPLAY OF MARINE ELECTRONICS
N. J. Distributors: Apelco - Ray - Jefferson - Bendix Aerotron - RCA
Radio Telephones - Auto-Pilots - D F - Radar
2 Way Radio Equipment for Medical Radio Service

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

Place	Name and Address	Telephone
BERGENFIELD	Horn's Pharmacy, 475 So. Washington Ave.	DUmont 4-1119
BLOOMFIELD	Burgess Chemist, 56 Broad St.	PIlgrim 3-1005
CLOSTER	Mid Town Pharmacy, 237 Closter Dock Road	PO. 8-0070
DUMONT	Lenrow's Pharmacy, Inc., 10 W. Madison Ave.	DUmont 4-0842-1500
EDISON TOWNSHIP	Walter's Pharmacy, 1034 Amboy Ave.	LIberty 8-2614
EMERSON	Emerson Pharmacy, 201 Kinderkamack Road	COlfax 2-4999
FARMINGDALE	Burke Rexall Drugs, Main St. opp. Bank & Post Office	WEbster 8-9051
HIGHLANDS	Highlands Pharmacy, 148 Bay Ave.	872-1550
JERSEY CITY	J. B. Feinberg Pharmacy, 659 Newark Ave.	OLdfield 3-6376
JERSEY CITY	Fred T. Fiore, 14 Rose Ave.	DElaware 3-7509
JERSEY CITY	Honiberg Drug & Surgical Supply Co., 618 Newark Ave.	SWarthmore 8-6700
JERSEY CITY	Lauria's Pharmacy, 768 West Side Ave.	HEnderson 3-1519
KEYPORT	Sav-On-Drugs, J. Meisler, opp. Post Office.	COlfax 4-0904
LAKEWOOD	Burke Rexall Drugs, Cor. 4th and Monmouth	FOxcroft 3-7133
MILLTOWN	Milltown Pharmacy, 21 No. Main St.	MIlltown 8-0081
MILLVILLE	Richard H. Knowles Pharmacy, 600 No. High St.	TAylor 5-0721
MORRISVILLE, PA.	Pryor's Pharmacy, Bridge St. & Penna Ave.	Cypress 5-7416
MOUNT HOLLY	Mount Holly Pharmacy, 64 Main St.	AMherst 7-0453
NEWARK	Giannotto's Pharmacy, 195 First Ave.	HUmboldt 2-8220
NEWARK	Marquier's Pharmacy, Sanford and So. Orange Aves.	ESsex 3-7721
NEW BRUNSWICK	Bode Pharmacy, 120 French St.	KIlmer 5-2676
NEW BRUNSWICK	Tobin's Drug Store, 335 George St.	CHarter 9-0780
NEW BRUNSWICK	Zajac's Pharmacy, 225 George St.	KIlmer 5-0582
OCEAN CITY	Selvagn's Pharmacy, 862 Asbury Ave.	OCean City 3535
ORANGE	Highland Pharmacy, 536 Freeman St.	ORange 3-1040
PASSAIC	Wollman Pharmacy, 143 Prospect St.	PRescott 9-0081
PATERSON	Vallario's Pharmacy, 357 Totowa Ave.	ARmory 4-2139
PAULSBORO	Nastase's Pharmacy, 762 Delaware St.	PAulsboro 8-1569
PENNSAUKEN	Thor's Rexall Drugs, 4919 Westfield Ave.	NOrmandy 2-0848
PRINCETON	The Thorne Pharmacy, 168 Nassau St.	WAlnut 4-0077
RAHWAY	Kirstein's Pharmacy, 74 East Cherry St.	FUlton 8-0235
RIDGEFIELD PARK	Lloyd's Prescriptions, 209 Main St.	DIamond 2-8383
RUMSON	Rumson Pharmacy, W. E. Fogelson	842-1234
SOUTH AMBOY	Madura Pharmacy, 115 N. Broadway	PArkway 1-1732
SOUTH AMBOY	Peterson Pharmacy, 132 No. Broadway	PArkway 1-0137
TRENTON	Adam & Sickles, State & Prospect Sts.	OWen 5-6396
TRENTON	Episcopo's Pharmacy, Chambers & Liberty Sts.	EXport 3-3017
TRENTON	Foy's Drug Store, 3024 So. Broad St.	EXport 3-2367
UNION	Colonial Rexall Pharmacy, 1448 Morris Ave.	MUrdock 7-3100
UNION	Perkins Union Center Pharmacy	MUrdock 6-0877
WEST NEW YORK	Gemignani Pharmacy, 6129 Park Ave.	UNion 5-1296
WEST NEW YORK	The Owl Pharmacy, 6611 Bergenline Ave.	UNion 5-0384
WEST ORANGE	West Orange Pharmacy, 443 Main St.	ORange 4-9824
WRIGHTSTOWN	Bowen's Pharmacy, 152 Fort Dix Road	RAymond 3-2176

CUNNINGHAM BROS., Inc.

Meats, Poultry & Provisions - - - Since 1882

700 BROOK AVENUE • NEW YORK 55, N. Y. • MO 5-2700

LAFAYETTE RADIO of Newark

Headquarters for . . .

STEREOPHONIC
HIGH FIDELITY
SYSTEMS and
COMPONENTS
for Home and Office

•

Lafayette Radio

24 Central Ave. - Newark 2

Phone: MArket 2-1661

GRAY, Inc.

FUNERAL DIRECTOR

•

F. H. Gray, Jr.
CRANFORD, N. J. — WESTFIELD, N. J.

Raymond A. Lanterman & Son

EXCLUSIVE FUNERAL SERVICE

126 SOUTH STREET
MORRISTOWN, N. J.

Phone JE 9-2880

R. A. Lanterman Wm. V. D. Lanterman

AUG. F. SCHMIDT & SON

E. G. SCHMIDT ANDERSON, Manager

FUNERAL HOME

139 Westfield Avenue **Elizabeth, N. J.**



THE COLONIAL HOME

W. N. KNAPP & SONS

Directors of Funerals

W. NELSON KNAPP II, President

Licensed Director

132 South Harrison Street, East Orange, N. J.
Telephone OR 3-3131

REPRESENTATIVE FUNERAL DIRECTORS

OF THE STATE OF NEW JERSEY

Special and Dependable Service Day and Night. Special Attention Given to Hospital Calls, Train and Express Shipments.

Place	Name and Address	Telephone
ADELPHIA	C. H. T. Clayton & Son	FReehold 8-0583
BLOOMFIELD	George Van Tassel's Community Funeral Home	PIlgrim 3-1234
CRANBURY	A. S. Cole Son & Co., Main St.	EXport 5-0770
ENGLEWOOD	Greenleaf Funeral Home, Inc., 108 W. Palisade Ave.	LOwell 8-0416
FREEHOLD	Higgins Memorial Home, 20 Center St.	HOpkins 2-0895
METUCHEN	Runyon Mortuary, 568 Middlesex Ave.	LIberty 8-0149
NEWARK	Barrish Funeral Home, 684 Clinton Ave.	ESsex 3-1551—9179
PATERSON	Legg, R. Charles D. & Sons, 384 Broadway	SHerwood 2-2385
RAMSEY	The Harold Van Emburgh Funeral Home, Inc.	DAvis 7-0030
RIDGEWOOD	C. C. Van Emburgh, Inc., 306 E. Ridgewood Ave.	GIlbert 5-0344
SOUTH RIVER	Rezem Funeral Home, 190 Main St.	SOuth River 6-1191
TRENTON	Ivins & Taylor, Inc., 77 Prospect St.	EXport 4-5186

DUGAN'S

"Bakers for the Home"

New - LITE DIET BREAD

(White Bread Baked Without Shortening)

Calories per Slice 42 Calories per oz. 70

ALSO

SALT-FREE BREAD
GLUTEN AND PROTEIN BREADS
100% WHOLE WHEAT
100% Whole Wheat Crackers

New York New Jersey
Connecticut Pennsylvania

"At Your Door or To Your Store
It's DUGAN'S for BETTER Baked Goods"

Phone for Delivery

HUmboldt 2-6007 in Newark

(or your local phone book for branch nearest you)

WOULD YOUR OFFICE RENT STOP . . . IF YOU WERE HOSPITALIZED FOR SIX MONTHS?

Of course not! That's just one of the reasons why wise physicians and dentists take advantage of broad new benefits available in our "Loss of Time" policy.

We pay YOU each month when you are hospitalized or disabled.

For full details, at no obligation, simply send the coupon below.

PHYSICIANS MUTUAL INSURANCE CO.
formerly
Physicians Casualty and Health Associations
"The Doctors Company"
Insuring Physicians & Dentists for 60 years.

Physicians Mutual Insurance Company
115 So. 42nd Street
Omaha 31, Nebraska

Please send details on your "Loss of Time" policy.

NAME_____ AGE_____

ADDRESS_____

CITY_____ STATE_____

HOLLOW ACRYLIC SPHERES
For Thoracic Surgery

Internally Sterilized by Special Ultra-Violet Lamps

Vacuum Tested to Insure Freedom from Defects

We are the Original Manufacturers of these Spheres and Make Only Quality Products

PRICE LIST

	1" dia.	1¼" dia.	1½" dia.	2" dia.
Less than 500	$.40 ea.	$.50 ea.	$.55 ea.	$.75 ea.

Quantity Prices Supplied Upon Request

Nichols Products Company

Moorestown, N. J.

B-D

BECTON, DICKINSON & COMPANY

EAST RUTHERFORD

"Prescribe with Confidence"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR
FOR MEN - WOMEN - CHILDREN



SOLD ON Rx ONLY
OUTFLAIR SHOES
FOR CLUB FEET

177A JEFFERSON AVE.
PASSAIC, N. J.

69 WESTWOOD AVE.
WESTWOOD, N. J.

350 MAIN ST.
HACKENSACK, N. J.

Dennis Brown Splints — in all sizes — carried in stock

LONG TERM AUTO LEASING

. . . A SERVICE ESPECIALLY PLANNED FOR DOCTORS!

M.D. PLATES FREE, TOO!

AAL LONG TERM SINGLE CAR AND FLEET RENTALS

Call ORange 6-7137 or

MAIL COUPON TODAY

Lease a brand new Cadillac or other fine car from American and you'll never **buy** again. Save money, time and trouble. One modest monthly payment takes care of everything . . . insurance, maintenance, repairs, depreciation . . . and the payments are 100% tax deductible! Borrow a car—free of charge—in case of accident or breakdown.

INCLUDES

- Registration and plates
- Full maintenance
- Insurance

Liability $250/$500,000
Property damage $20,000
Deductible collision,
fire and theft

AMERICAN AUTO LEASING COMPANY
120 Halsted St., East Orange, N. J.
Please send me the AAL Long Term Leasing Plan.

Wide Selection of '63 Models

Special requirements _____

_____

Name _____

Address _____

City _____ State _____

ALL YOU BUY IS GAS AND OIL

ASK FOR BROCHURE

AAL

AMERICAN AUTO LEASING COMPANY

120 Halsted Street, East Orange, New Jersey • ORange 6-7137

Ranch Type - Luxurious

THE PARKWAY NURSING HOME, INC.



1201 PARKWAY AVE.

Trenton, N. J.

882-6900

No Steps!
New audio-visual intercom system from every patient to Nurses.

One of New Jersey's newest, most modern and completely equipped Nursing and Convalescent Homes, catering to the Convalescent, Aged, and Chronically Ill.

Referring physician has full medical privileges
Complete 24-hour general nursing care
Physical rehabilitation department
Beauty parlor — air-conditioned dining room, lounge, and lobby — spacious patios

Ultra modern interiors with artistic color scheme
Stainless steel kitchen tiled to ceiling
Special diets — planned social and recreational activities

Residential Section
Reasonable Rates

The Parkway Nursing Home

NEW JERSEY STATE LICENSED

MEMBER OF AMERICAN NURSING HOME ASSOCIATION

CLASSIFIED ADVERTISEMENTS

WANTED FOR SALE TO LET
SITUATIONS, ETC.

Send replies to box number c/o The Journal
P. O. Box 904, Trenton 5, N. J.

$3. for 25 words or less; additional words 5c each
Forms close 15th of the preceding Month.

CHIEF OF PATHOLOGY-DIRECTOR OF LABORATORIES—Board eligible. 120-bed voluntary general hospital with major expansion program. JCAH accredited. Rural lake area, 50 miles from New York City. Minimum guarantee from $25,000. Contact: Administrator, Newton Memorial Hospital, Newton, New Jersey.

RESIDENT PHYSICIANS—Our resident staff is composed of five retired physicians. We can accommodate two additional resident physicians with New Jersey licenses. Salary open. Pinehaven Nursing Home & Sanitarium, Inc., Joseph O. Smigel, Executive Director, Bayville, New Jersey. DI 9-2050.

STAFF PHYSICIANS—For JCAH approved county chest disease hospital; must have New Jersey license; salary open, fringe benefits, maintenance at nominal cost. Contact Irving Ocheret, M.D., Superintendent, Essex County Sanatorium, Verona, New Jersey.

TWO HOUSE PHYSICIANS WANTED—For one year beginning July 1, 1963, in 130-bed general hospital; one for medical patients and one for surgical patients. One year accreditation in general surgery. University teaching affiliations. Salary—$10,000 plus benefits. State license or ECFMG certificate required. Apply to: William Y. Inouye, M.D., Jeanes Hospital, Philadelphia 11, Pennsylvania.

PHYSICIANS WANTED—Male and female, licensed, for children's camps, July-August. Good salary, free placement. 350 member camps. Department p, Association Private Camps, 55 West 42nd Street, New York 36, New York.

ASSOCIATE WANTED—Surgeon desires associate with interest in internal medicine to run large practice. Excellent remuneration. Eventual partnership. Call HU 4-7878.

ANESTHESIOLOGIST—Fellow and Diplomate, desires to relocate in large or small hospital as departmental head. Will consider solo or group. Write Box 55, c/o The Journal.

YOUNG INTERNIST—Gastroenterologist. University-trained, board eligible. Desires association with another internist or small group. Training includes gastrointestinal radiology. Write Box No. 61, c/o The Journal.

PEDIATRICIAN—Board certified, desires association with partnership or group. Write Box No. 60, c/o The Journal.

POSITION WANTED—Medical Assistants and Secretaries. Laboratory and X-Ray Techs. Well-trained and highly-qualified personnel (male and female) available. Phone CH 2-2330, Ext. 17, Placement Department, or write Physician Director, Eastern School for Physicians' Aides, Department 7, 85 Fifth Avenue, New York 3, New York.

GENERAL PRACTITIONER—Plans retirement. Will sell active practice or rent fully equipped office. At same location for over 50 years. Newark, New Jersey. Write Box No. 56, c/o The Journal.

UPPER MONTCLAIR OFFICE TO SHARE—Air-conditioned. Recently occupied by Internist. 500 ma. X-ray, EKG and lab. available. Call PI 4-3636.

WEST ESSEX MEDICAL CENTER—Suites available to specialists. Full or part-time basis. Excellent location and facilities for suburban practice. Write: Stanley S. Fieber, M.D., 588 Eagle Rock Avenue, West Orange, New Jersey; or call RE 1-0011.

PROFESSIONAL BUILDING—New, fully air-conditioned. Prestige East Orange location. Convenient New York and local transportation. Rooms, suites arranged to your requirements. Parking on premises. Write Box No. 58, c/o The Journal.

FOR SALE BRIDGETON—New Jersey. Excellent, long-established medical practice. Fully equipped, air-conditioned modern offices, X-ray, etc. Residence included. Write: Mrs. Helen Korican, 188 North Pearl Street, Bridgeton, New Jersey.

FOR SALE—Fully equipped medical center in a new and growing community in Central New Jersey. Write Box No. 59, c/o The Journal.

FOR SALE—Residence, apartment, and adjoining professional offices in a central New Jersey community with tremendous growth potential. Established doctor's location, highly desirable for specialized practice. For complete details consult Claudia Pascale, Realtor, 68 North Bridge Street, Somerville. RA 2-1032.

HOUSE FOR SALE—Roseville Avenue, Newark. Doctor's office, first floor; living quarters, second and third floors. HU 2-6655.

CLASSIFIED ADVERTISEMENTS

OFFICES FOR RENT—Equipped offices of deceased general practitioner. Wonderful opportunity. For summer season or year round. Will introduce. Stanley Hornstine, 4004 Pacific Avenue, Wildwood, New Jersey.

FOR RENT—Tenafly, New Jersey (5 miles George Washington Bridge). Doctor's office and house, corner location. Opportunity to practice with minimal outlay. Lease. LO 8-8687.

FOR RENT—Demarest, New Jersey (Bergen County) (7 miles George Washington Bridge). Medical office. Brand-new building. Waiting, examining, consulting rooms; nurses station. Available August. LO 8-8687.

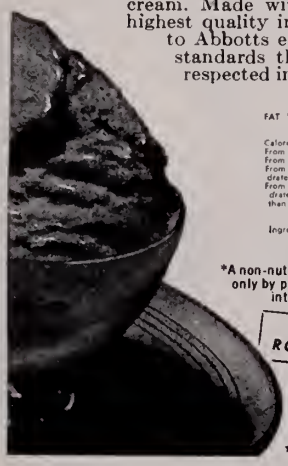
OFFICE FOR RENT—Irvington, New Jersey, opposite hospital, was physician's office for over 20 years. Records of recently deceased physician available. Will rent either fully equipped or unequipped. Bus lines stop at door. Phone SO 3-3663 or SO 3-0277.

FOR RENT—IRVINGTON. Well-established attractive office. Two street entrances, 4 rooms, partly furnished, air-conditioning. Heat included in reasonable rent. May 1st. Call evenings ES 2-6712 or write Box No. 57, c/o THE JOURNAL.

NOW! DIABETICS CAN ENJOY
(UNDER MEDICAL ADVICE)

Abbotts
ARTIFICIALLY SWEETENED
ICE CREAM

Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards—standards that are most highly respected in the dairy industry



COMPOSITION
FAT 10.52% PROTEIN 3.71%
CARBOHYDRATES 20.40%

		Oz	Oz
Calories —	Per 100 Gm.	Avdp.	Fluid
From Fat	94.68	26.84	16.25
From Protein	14.84	4.21	2.55
From Carbohydrates as Lactose	20.24	5.74	3.47
From Carbohydrates other than Lactose	61.66	17.48	10.58
	191.42	54.27	32.85

Ingredients: Cream, Milk, Sorbitol, Stabilizer and 0.11% Cyclemate Calcium*

*A non-nutritive artificial sweetener for use only by persons who must restrict their intake of ordinary sweets.

IN HANDY ROUND PINTS

At Abbotts and Jane Logan Dealers
Abbotts Dairies



Of special significance to the physician is the symbol

When he sees it engraved on a Tablet of Quinidine Sulfate he has the assurance that the Quinidine Sulfate is produced from Cinchona Bark, is alkaloidally standardized, and therefore of unvarying activity and quality.

When the physician writes "DR" (Davies, Rose) on his prescriptions for Tablets Quinidine Sulfate, he is assured that this "quality" tablet is dispensed to his patient.

Rx Tablets Quinidine Sulfate Natural
0.2 Gram (or 3 grains)
Davies, Rose

Clinical samples sent to physicians on request

Davies, Rose & Company, Limited
Boston 18, Mass.

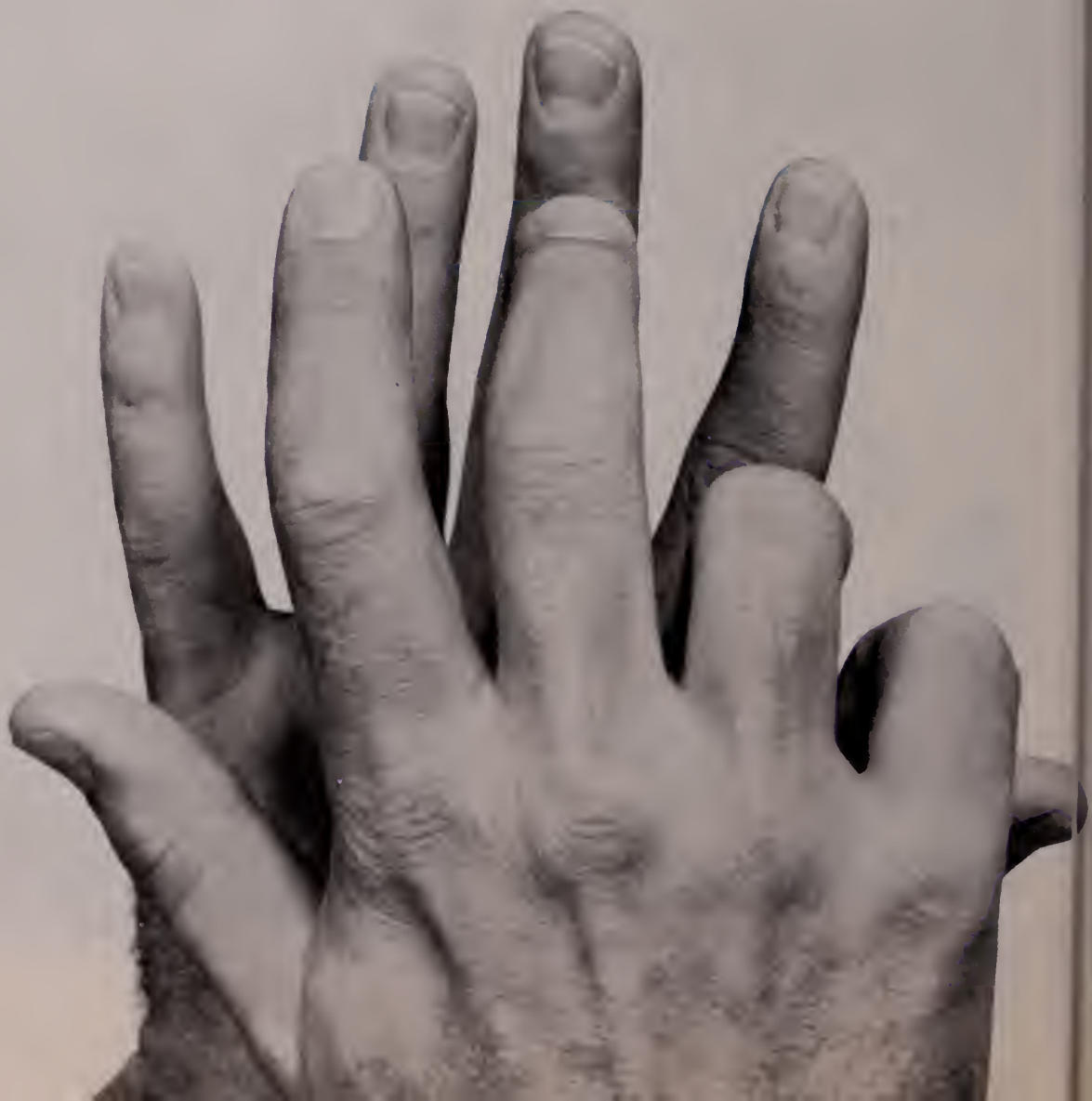
0-7

in severe respiratory infections refractory to other measures

CHLOROMYCETIN®

(chloramphenicol, Parke-Davis)

for established clinical efficacy against susceptible organisms*



In Friedlander's Pneumonia[3,13]

Although the prognosis in Friedlander's pneumonia is poor, treatment with CHLOROMYCETIN has shown a good response when susceptible strains of *Klebsiella pneumoniae* are incriminated.

In *Hemophilus Influenzae* Pneumonia[3,4,13,14]

Because the invading organism is usually sensitive to CHLOROMYCETIN, this agent is generally effective in pneumonias caused by *H. influenzae*.

In Staphylococcal Pneumonia[1-8,13]

CHLOROMYCETIN continues to remain effective against many resistant strains of staphylococci, and—alone or in combination with other antibiotics—should be considered when other antistaphylococcal drugs are ineffective.

In Acute Epiglottitis[4,10,11]

This condition is most often caused by *H. influenzae*, most strains of which are sensitive to CHLOROMYCETIN. Therapy should be instituted at once, since the disease may progress from the first symptoms to a severe respiratory obstruction in four to six hours.

In Pneumonias Due to Gram-negative Bacilli[9]

Because of its broad-spectrum activity, CHLOROMYCETIN is often effective in pneumonias caused by sensitive strains of *Aerobacter, Proteus* of various species, *Paracolobactrum,* and other gram-negative pathogens encountered with increasing frequency in serious respiratory tract infections.

In Staphylococcal Empyema[12]

The infiltrating lesions of staphylococcal empyema are often difficult to eradicate. While CHLOROMYCETIN should only be used when the infection has been resistant to treatment with other antistaphylococcal drugs, therapy with CHLOROMYCETIN, in conjunction with surgical procedures, will often bring favorable results.

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100. See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections such as colds, influenza, or viral infections of the throat, or as a prophylactic agent.

Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Thacher, H. C., & Fishman, L.: *J. Maine M. A.* **52**:84, 1961. (2) Hopkins, E. W.: *Postgrad. Med.* **29**:451, 1961. (3) Hall, W. H.: *M. Clin. North America* **43**:191, 1959. (4) Krugman, S.: *Pediat. Clin. North America* **8**:1199, 1961. (5) Ede, S.; Davis, G. M., & Holmes, F. H.: *J.A.M.A.* **170**:638, 1959. (6) Wolfsohn, A. W.: *Connecticut Med.* **22**:769, 1958. (7) Calvy, G. L.: *New England J. Med.* **259**:532, 1958. (8) Hendren, W. H., III, & Haggerty, R. J.: *J.A.M.A.* **168**:6, 1958. (9) Cutts, M.: *Rhode Island M. J.* **43**:388, 1960. (10) Berman, W. E., & Holtzman, A. E.: *California Med.* **92**:339, 1960. (11) Vetto, R. R.: *J.A.M.A.* **173**:990, 1960. (12) Sia, C. C. J., & Brainard, S. C.: *Hawaii M. J.* **17**:339, 1958. (13) Rosenthal, I. M.: *GP* **17**:77 (March) 1958. (14) Gaisford, W.: *Brit. M. J.* **1**:230, 1959.

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan

03863

specific for anxiety & tension

Librium

The singular specificity of Librium in controlling anxiety and tension has proven to be an advantage in a wide range of disorders characterized by anxiety of varying degrees. Notably effective in patients whose symptoms are primarily emotional, Librium is equally valuable when organic disease is aggravated or prolonged by accompanying anxiety. Coupled with its effectiveness is an outstanding record of safety. Librium has few, if any, of the unwanted side effects associated with tranquilizers and daytime sedatives—no extrapyramidal effects, no autonomic blocking, and no dulling of mental alertness. Consult literature and dosage information, available on request, before prescribing.

the successor to the tranquilizers

LIBRIUM® Hydrochloride—7-chloro-2-methylamino-5-phenyl-3H-1,4-benzodiazepine 4-oxide hydrochloride

ROCHE

ROCHE

THE Journal OF

THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since 1904

Copyright 1963 by The Medical Society of New Jersey

Entered as second-class matter Sept. 5, 1906, at the post office, Orange, N. J., under Act of March 3, 1879
Second Class Postage Paid at Orange, N. J.

VOL. 60, No. 5 MAY, 1963 35 Cents - $3.00 PER YEAR

NEW YORK ACADEMY OF MEDICINE LIBRARY MAY 27 1963

CONTENTS—Pages 181 to 222

EDITORIALS— Page

See You On The Boardwalk 181
Blue Shield Success Story 182
Stop Street to Medical Research 182

ORIGINAL ARTICLES—

Penetrating Abdominal Wounds—M. Idris, M.B., R. Ryan, M.D., and P. Bazinet, M.D., Trenton 183

Treatment of Tinea Versicolor—William C. Giordano, M.D., Ridgefield 186

Staphage Lysate Therapy in Staphylococcal Infections—George G. Salmon, Jr., M.D., Short Hills, and Margaret Symonds, M.B., B.S., New Vernon 188

The Interpretation of Abdominal Pain—Charles M. Thompson, M.D., Philadelphia, Pennsylvania 194

ORIGINAL ARTICLES— Page

A New Therapy for Osteoporosis—Herman H. Tillis, M.D., East Orange 200

LSD As A Therapeutic Tool—Gustav R. Schmiege, Jr., M.D., Haddonfield 203

ANNOUNCEMENTS 208

TRUSTEES' MINUTES—

February 17, 1963 209
March 17, 1963 214

OBITUARIES 216

LETTER TO THE JOURNAL 218

BOOK REVIEWS 219

RESPIRATORY DISEASE ABSTRACTS 221

Roster of Officers, Advertising Page 3A

The Medical Society of New Jersey Endorsed Plans of

ACCIDENT AND HEALTH INSURANCE
MAJOR MEDICAL EXPENSE INSURANCE
TERM LIFE INSURANCE

****SIX POINT, HIGH LIMIT ACCIDENT INSURANCE**
(Accidental Death, Dismemberment and other Accident Benefits)

Income Protection (Accident and Sickness Insurance)

$1,200 a month new maximum Basic total disability benefit

ACCIDENT: from 1st day, up to 5 years (Partial Accident Disability, half benefit up to six months)
SICKNESS: from 8th day, up to 2 years

$600 a month new maximum Extended total disability benefit, continuing benefits beyond basic coverage.

ACCIDENT: extended to LIFE
SICKNESS: extended through SEVENTH year

Major Medical

$10,000 maximum for Covered Expenses for each accident or sickness, covering member, spouse, and eligible children. $500 deductible, 20% co-insurance.

Life

$10,000 to **$50,000** of Convertible Term Life Insurance.
(Guaranteed exchangeable at any time into Permanent Cash Value life insurance)

Applications for initial $10,000 policy and additional $10,000 policies up to $50,000 total under this plan considered during the month of November each year*.

**** SIX POINT, HIGH LIMIT ACCIDENT INSURANCE**

Up to $200,000 Six Point, High Limit Accident Insurance, covering accidental death, dismemberment, loss of sight, total and permanent disability, exposure and disappearance for member.

Up to $100,000 for spouse (without disability benefit).

Applications are subject to age limits and other company rules and regulations for acceptance of risks. New members have special privileges during the first few months of membership; ask for specific details if you were recently elected and have not received notification from us.

Information and claim service are as close as your telephone.

E. & W. BLANKSTEEN
E. & W. Blanksteen Agency, Inc.
75 MONTGOMERY STREET JERSEY CITY 2, NEW JERSEY
DElaware 3-4340

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATON, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.
EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154
(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

OFFICERS

President, Louis S. Wegryn, M.D. ..... Elizabeth
President-Elect, Jerome G. Kaufman, M.D. ..... Maplewood
First Vice-President, Charles H. Calvin, M.D. .. Perth Amboy
Second Vice-President, John J. Bedrick, M.D. ..... Bayonne
Secretary, Marcus H. Greifinger, M.D. ..... Newark
Treasurer, Daniel F. Featherston, M.D. ..... Asbury Park
Mr. Richard I. Nevin, *Executive Director* ..... Trenton
Mrs. Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton

TRUSTEES

Samuel J. Lloyd, M.D., *Chairman* (1963) ..... Trenton
Nicholas A. Bertha, M.D., *Secretary* (1965) ..... Wharton
Louis S. Wegryn, M.D. ..... Elizabeth
Jerome G. Kaufman, M.D. ..... Maplewood
Charles H. Calvin, M.D. ..... Perth Amboy
John J. Bedrick, M.D. ..... Bayonne
Marcus H. Greifinger, M.D. ..... Newark
Daniel F. Featherston, M.D. ..... Asbury Park
Ralph M. L. Buchanan, M.D. ..... Phillipsburg
Louis F. Albright, M.D. (1964) ..... Spring Lake
Louis K. Collins, M.D. (1964) ..... Glassboro
Thomas C. DeCecio, M.D. (1965) ..... Cliffside Park
Joseph P. Donnelly, M.D. (1963) ..... Jersey City
Lloyd A. Hamilton, M.D. (1965) ..... Lambertville
Frank J. Hughes, M.D. (1963) ..... Gloucester
Joseph R. Jehl, M.D. (1963) ..... Clifton
Emanuel M. Satulsky, M.D. (1964) ..... Elizabeth
Carl N. Ware, M.D. (1965) ..... Ocean City

COUNCILORS

First District (Essex, Morris, Union, and Warren Counties) ..... Henry L. Hermann, M.D., Phillipsburg (1963)
Second District (Bergen, Hudson, Passaic, and Sussex Counties) ..... John L. Olpp, M.D., Englewood (1965)
Third District (Hunterdon, Mercer, Middlesex, and Somerset Counties) ..... Albert F. Moriconi, M.D., Trenton (1964)
Fourth District (Burlington, Camden, Monmouth, and Ocean Counties) ..... E. Vernon Davis, M.D., Moorestown (1963)
Fifth District (Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties).... Isaac N. Patterson, M.D., Westville (1963)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell, M.D. (1964) ..... Asbury Park
William F. Costello, M.D. (1963) ..... Dover
Joseph P. Donnelly, M.D. (1964) ..... Jersey City
Marcus H Greifinger, M.D. (1964) ..... Newark
Luke A. Mulligan, M.D. (1964) ..... Leonia
Isaac N. Patterson, M.D. (1963) ..... Westville

Alternates

F. Clyde Bowers, M.D. (1964) ..... Mendham
Frank J. Hughes, M.D. (1964) ..... Gloucester
Joseph R. Jehl, M.D. (1964) ..... Clifton
John F. Kustrup, M.D. (1964) ..... Trenton
Elton W. Lance, M.D. (1963) ..... Rahway
John L. Olpp, M.D. (1963) ..... Englewood

DELEGATES TO OTHER STATES

New York—William F. Costello, M.D. (1963) ..... Dover
Connecticut—Lloyd A. Hamilton, M.D. (1963) .. Lambertville
New York—G. Ruffin Stamps, M.D. (1963) .... Atlantic City
Connecticut—S. Eugene Dalton, M.D. (1963) ..... Ventnor

INFORMATION FOR READERS AND CONTRIBUTORS

The Journal is the official organ of The Medical Society of New Jersey, published monthly under the direction of the Committee on Publication. *The Journal* is released on or about the tenth of each month, and a copy is sent to each member of the Society.

Change of Address: Notice of change of address should be sent promptly to The Medical Society of New Jersey, P.O. Box 904, Trenton 5, New Jersey.

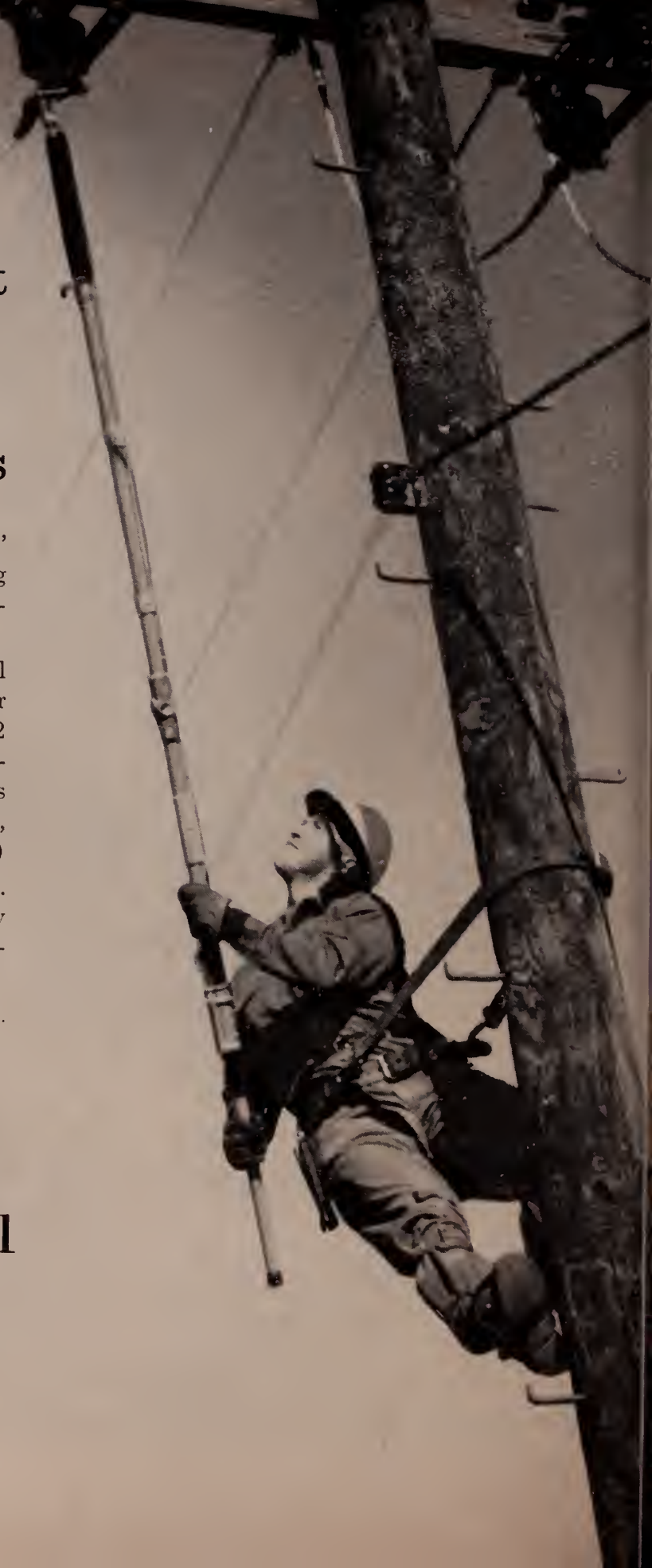
Communications: Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of any material in *The Journal*. All such communications should be directed to the Editorial Office of *The Journal*. The Publication Committee reserves the right to publish, reject, edit or abbreviate all communications submitted to it.

Contributions: Manuscripts submitted to *The Journal* should be typewritten, double-spaced on letter size (about 8¼ by 11 inch) paper and forwarded to the Editorial Office at the address below. The Publication Committee expressly reserves the right to reject any contributions, whether solicited or not; and the right to abbreviate or edit such contributions in conformity with the needs and requirements of *The Journal*. Galley-proofs of edited or abbreviated manuscripts will be submitted to authors for approval before publication. Every care will be taken with the submitted material, but *The Journal* will not hold itself responsible for loss or damage to manuscripts. Authors are required to submit original copies only, and are urged to keep carbon copies for reference. It is understood that material is submitted here for exclusive publication in this *Journal*.

Illustrations: Authors wishing illustrations for their articles will submit glossy prints or original sketches, from which cuts or plates will be made by *The Journal*. The cost of making such cuts will be borne by the author, who will, after publication, receive the cuts for his own use. The cost of these cuts varies with the size and type of the illustration. An estimate of the cost will be submitted to authors before the cuts are ordered.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY
P. O. Box 904, Trenton 5, New Jersey

Get your low-back patient back to work in days instead of weeks



You can expect rapid results from 'Soma' (carisoprodol)—because this unique drug breaks up both the spasm and pain of low-back syndrome at the same time.

Your patients will usually begin to feel better within a few hours. And as Kestler demonstrated in a controlled study of 212 consecutive patients with low-back problems: the average time for full recovery was only 11.5 days with 'Soma' (carisoprodol), 21 days without it. (J.A.M.A., April, 1960.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely.

USUAL DOSAGE: ONE 350 MG. TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

Soma®
carisoprodol

Wallace Laboratories
Cranbury, New Jersey

Milestones in Nutrition

1913

when vitamin A was missing...

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

☆ they turned to milk. In 1913 McCollum and Davis found that the need for an unidentified growth factor could be met by small amounts of butterfat. The factor eventually was identified as vitamin A.

One function of vitamin A is established: it is required for the formation of visual pigments essential to normal vision. The reasons for growth failure in vitamin A deficiency, however, are still not clear. A half century after its discovery, vitamin A remains an active subject of research.

An adequate intake of vitamin A is obtained by eating a balanced diet based on the four main food groups: milk and other dairy foods, meats and eggs, vegetables and fruits, bread and cereals. Dairy foods represent the main source of preformed vitamin A for children . . .while vegetables and fruits contribute most to the total vitamin A value.

As they have in the past, milk and other dairy foods will continue to play a vital role in the nutritional welfare of our people.



Since 1915 . . . promoting better health through nutrition research and education

NATIONAL DAIRY COUNCIL

a non-profit organization

202 EAST 44TH STREET • NEW YORK 17, NEW YORK

AVAILABLE ON REQUEST: Reprints of this series of messages on "MILESTONES IN NUTRITION" and "CALORIE RESTRICTED DIETS"

Solfoton®

for mild, continuous sedation

Each tablet (or capsule) contains 16 mg. phenobarbital blended with 65 mg. Bensulfoid®. The Bensulfoid is an inert diluent present to permit slow absorption of the phenobarbital. The usual dosage is one tablet or capsule after meals and at bedtime. Solfoton is especially adapted to prolonged use because of its virtual freedom from depression and other side effects. Contra-indications: identical to those of ¼ gr. phenobarbital.

REFER TO PDR

Poythress, White Section, Page 808 (1963 edition) and Product Identification Section

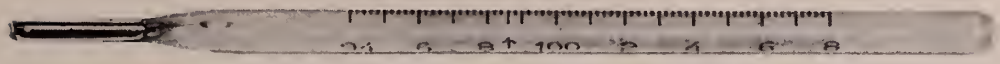
COMPLETE INFORMATION AND CLINICAL SAMPLES SENT UPON REQUEST

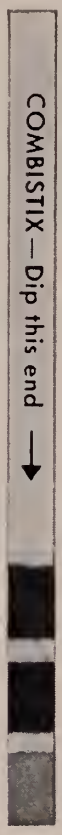
Dispensed in bottles of 100 and 500 tablets or capsules

WM. P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856

one answer... three minutes





three answers ...ten seconds

DIP AND READ

combistix®

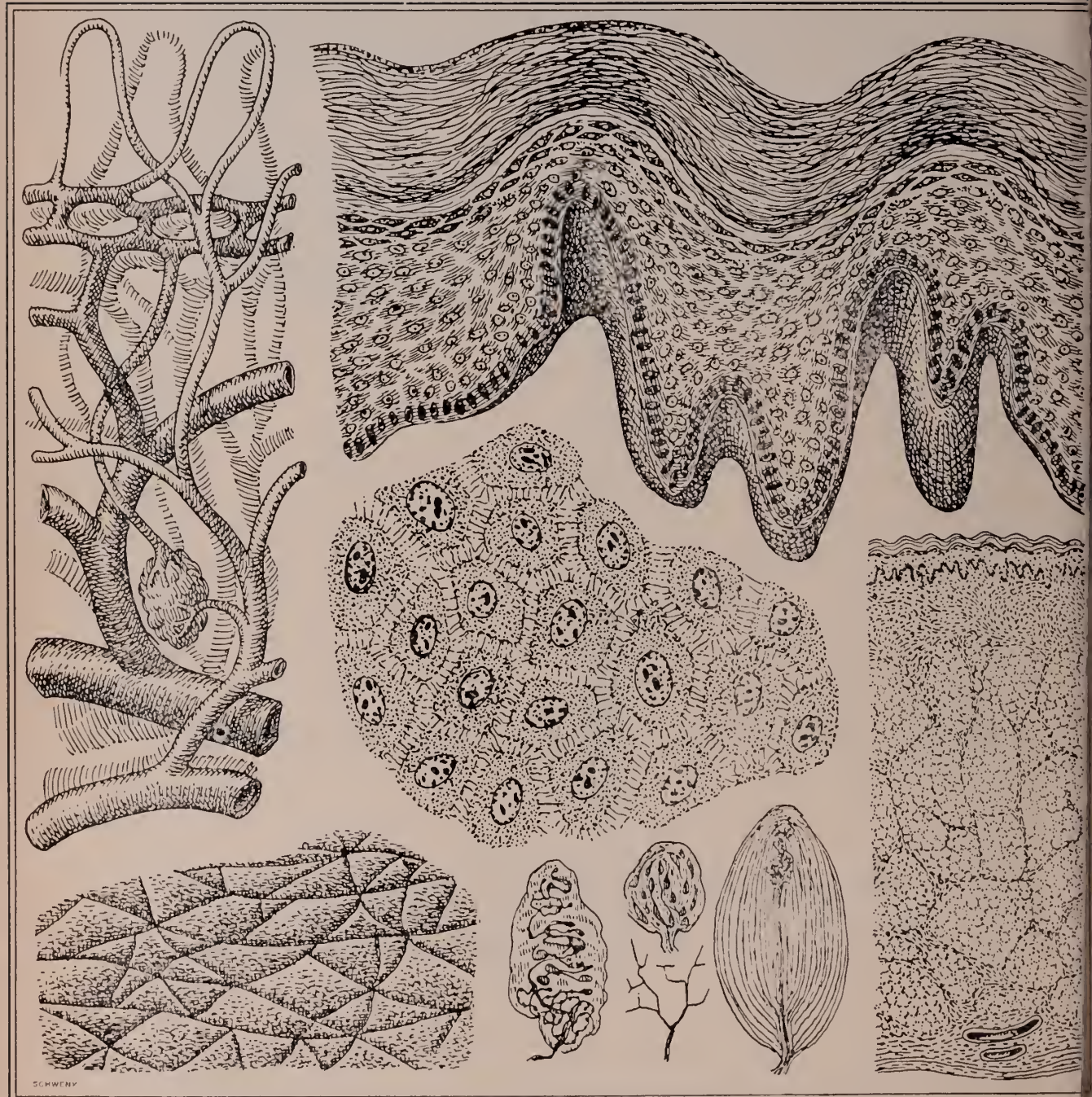
urine protein • glucose • pH

BASIC COMBINATION TEST FOR BEDSIDE AND OFFICE

. . . faster than taking temperature. Detects glucosuria (as in diabetes), proteinuria (as in renal disorder), abnormal pH (as in calcinosis or GU infection). For routine screening of all patients. COMBISTIX—*basic as the stethoscope.*

AMES products are available through your regular supplier. 38263

AMES
COMPANY INC
Elkhart • Indiana
Toronto • Canada


SCHWENK

Skin Deep

llergic and inflammatory dermatoses, ıcluding psoriasis, have in many patients ıown dramatic response to ARISTOCORT riamcinolone systemic therapy. But it also rovides gratifying symptomatic control ith only minimal interference with ther metabolic functions. In this respect, RISTOCORT Triamcinolone, when com- ared with other corticosteroids, old and new, s distinguished. Typical steroid problems of odium retention and edema, undesirable uphoria, or voracious appetite and excessive eight gain rarely occur.

RISTOCORT Triamcinolone is indicated hen anti-inflammatory, anti-allergic action f glucocorticoids is desired. SIDE EFFECTS of lucocorticoids generally: Cushingoid effects, irsutism, leucopenia, purpura, vertigo, fatigue, increased hyperglycemia, osteoporosis, gastrointestinal hemorrhage, cataracts, growth suppression in children and increased intracranial pressure. Other glucocorticoid effects thought more likely to occur with triamcinolone: reversible weakness of muscles and flushing of face.

PRECAUTIONS: ARISTOCORT Triamcinolone should be used with extreme caution in viral infection, particularly herpes simplex and chicken pox, in tubercular or fungal infection, in active peptic ulcer, acute glomerular nephritis or myasthenia gravis.

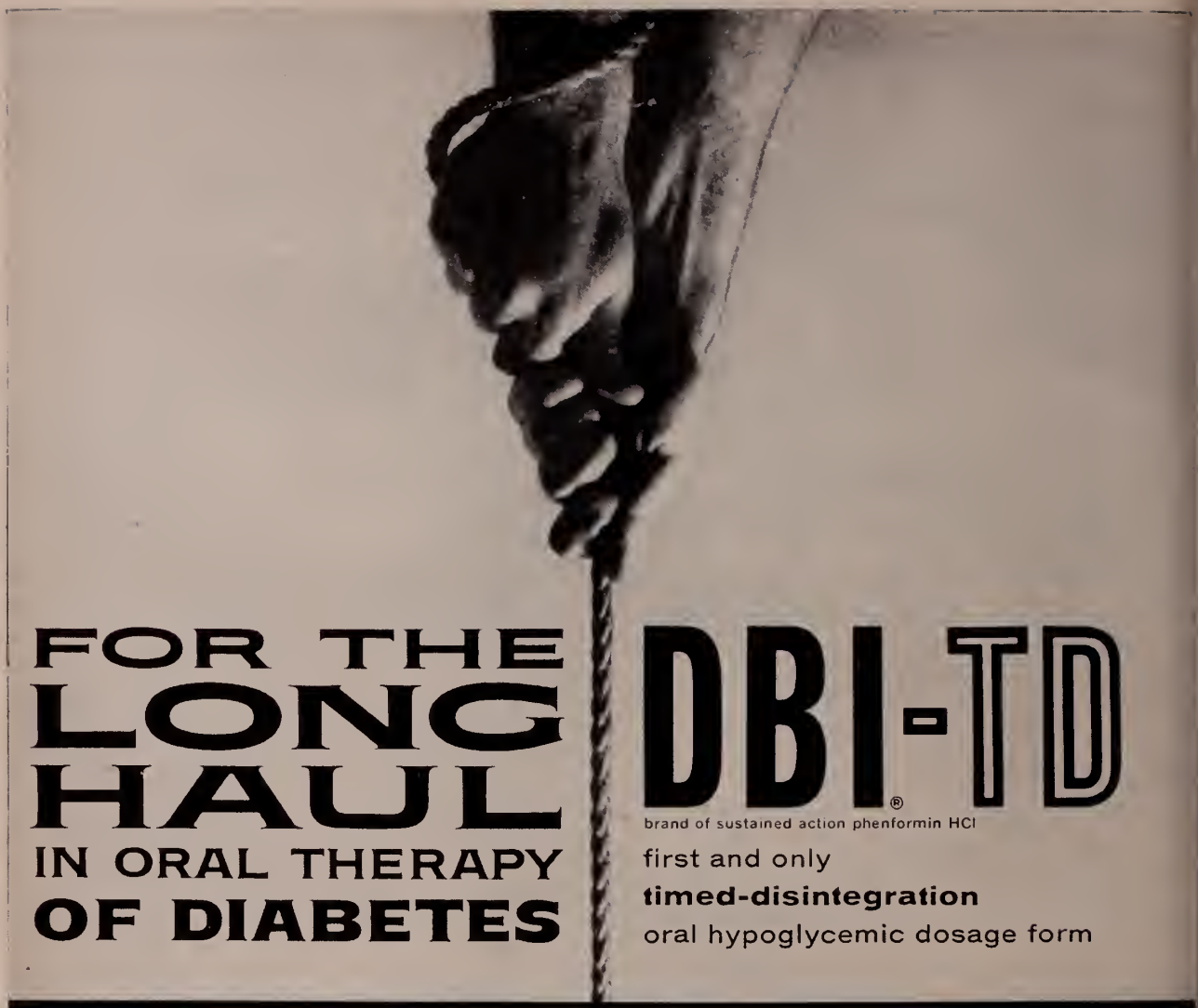
FORMULA—Tablets (scored) containing 1 mg., 2 mg. or 4 mg. of triamcinolone. Syrup — 2 mg. of triamcinolone diacetate per 5 cc. (5 mg. of triamcinolone diacetate is equivalent to 4 mg. of triamcinolone).

Aristocort®
Triamcinolone

Maximum steroid benefits with minimum steroid penalty

Lederle LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

164-R-3 (DC31-S)



FOR THE LONG HAUL IN ORAL THERAPY OF DIABETES

DBI®-TD

brand of sustained action phenformin HCl

first and only
timed-disintegration
oral hypoglycemic dosage form

long term response...“Secondary failure is unlikely to occur” with phenformin[4] (DBI-TD capsules, DBI tablets). Phenformin has been successfully administered daily in diabetics in one study for over 3 years[2] and in another for up to 4½ years[1] with “a virtual absence of acquired resistance or true secondary failure.”[1] Indeed, DBI has produced a satisfactory response in 55 to 60% of tolbutamide secondary failures.[3,7]

long term clinical safety... No liver or parenchymal organ toxicity has been observed after up to 2½ years of daily use of DBI-TD — nearly 5 years with the DBI tablets.[1,2,9] “The absence of hypoglycemic reactions” with phenformin “has been conspicuous.”[5]

long term tolerance... DBI-TD is well tolerated with minimal g.i. side effects.[2,6,8] Radding et al.[6] report, “the relative freedom from gastrointestinal side effects was particularly reassuring... and in no instance was it necessary to discontinue the drug.”

long term convenience... Once a day dosage — or at most twice a day — for great majority of diabetics makes DBI-TD simple and convenient therapy. Each dose lowers blood sugar gradually, smoothly, for about 12 to 14 hours.[6]

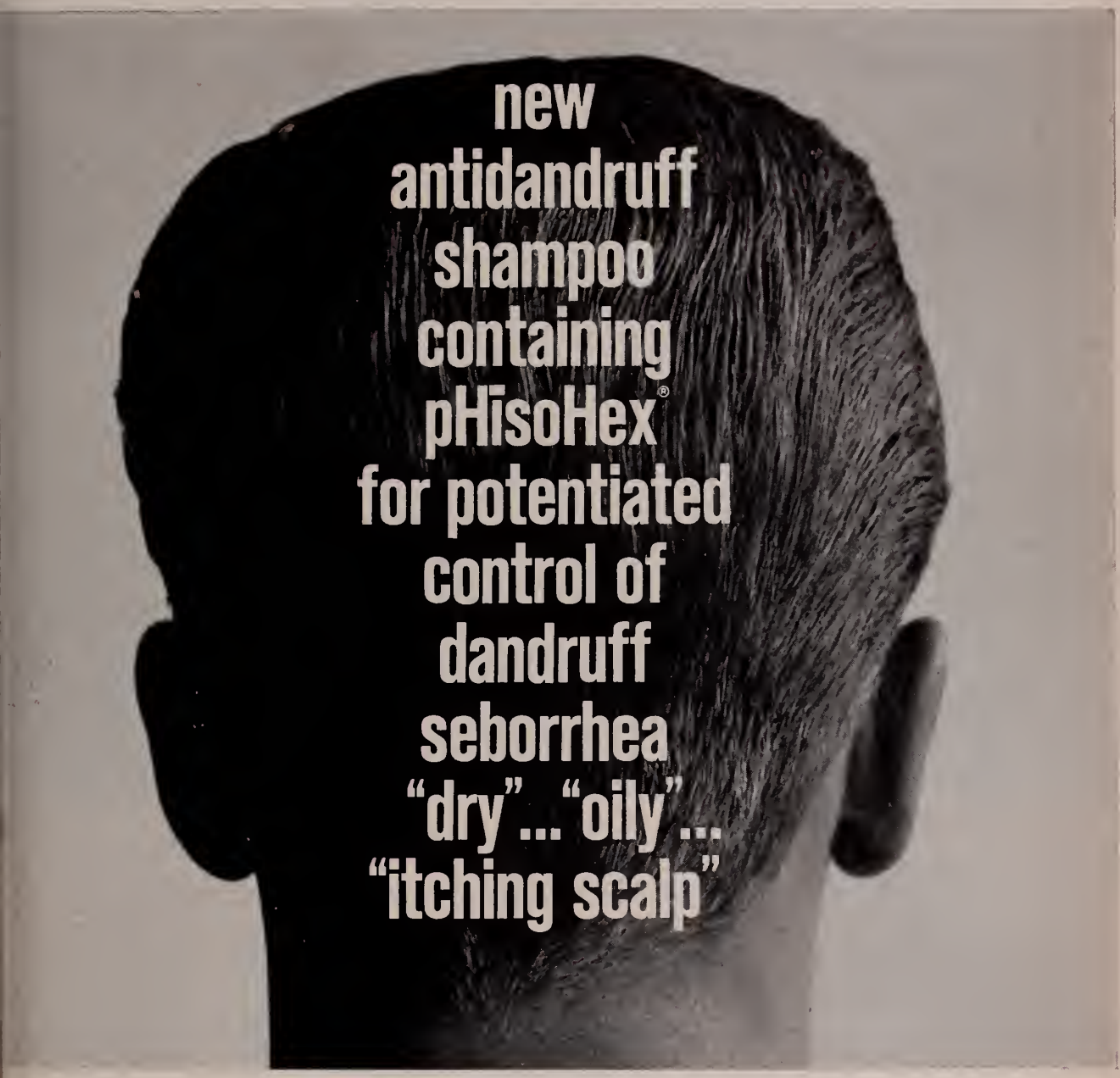
DBI-TD (brand of Phenformin HCl — N^1-β-phenethylbiguanide HCl) available as 50 mg. timed-disintegration capsules; bottles of 100 and 1000 capsules. Also available as DBI tablets, 25 mg., bottles of 100 and 1000.

Important: Before prescribing DBI-TD, the physician should be thoroughly familiar with directions for use, including indications, dosage, possible side effects, precautions and contraindications. Write for complete literature.

1. Pomeranze, J.: Clinical Med. 8:1155, June 1961. 2. Krall, L. P. and Bradley, R. F.: Geriatrics 17:337, May 1962. 3. DeLawter, D. E. et al.: J.A.M.A. 171:1786, Nov. 28, 1959. 4. Perkin, F. S.: J.A.M.A. 173:36, May 7, 1960. 5. Pearlman, W.: Phenformin Symposium, Houston, Feb. 1959. 6. Radding, R. S. et al.: Metabolism 11:404, April 1962. 7. Gold, A. et al.: Applied Therapeutics 2:137, 1960. 8. Brown, G. D. and Gabert, H.: Applied Therapeutics 4:451, May 1962. 9. Gold, A.: Applied Therapeutics 4:466, May 1962.

u. s. vitamin & pharmaceutical corporation
800 Second Ave., New York 17, N.Y.

pHisoDan*



ew pHisoDan provides the exceptionally beneficial itibacterial and the powerfully detergent actions of HisoHex (with hexachlorophene 3%) combined with e penetrating, keratolytic and fungicidal actions of specially prepared dermatologic sulfur (5%) and dium salicylate (0.5%). By a multiple therapeutic proach, pHisoDan quickly eliminates dandruff, sebor-eic scales, excessive oiliness or dryness and itching the scalp. Because pHisoDan contains pHisoHex, it eans hair thoroughly and keeps the scalp freer of icteria. It is also valuable in folliculitis, pyodermas and pustular eruptions of the scalp. In 1062 patients with seborrhea of the scalp (both sicca and oleosa), treated by 86 dermatologists, excellent or good results were obtained with pHisoDan in more than 90%.† Mild, gentle and with a pH adjusted to that of the skin, pHisoDan is nontoxic and nonirritating when used as directed. It does not stain or sting. pHisoDan should be used two or three times weekly until improvement is noted, thereafter once a week or as needed.

Available in 4¾ oz. squeeze bottles. Consult Winthrop literature for additional information.

demark †Data in the files of Research Department, Sterling Winthrop Institute

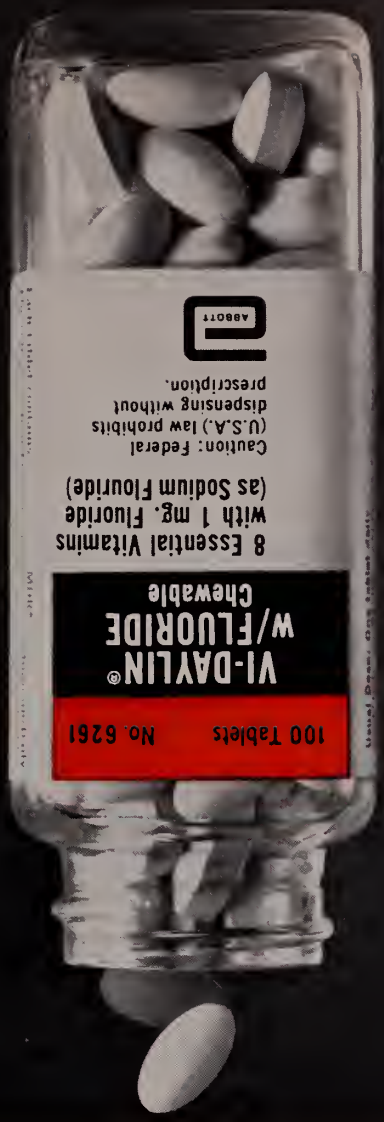
oHisoHex, trademark reg. U.S. Pat. Off.

NTHROP LABORATORIES, NEW YORK 18, N. Y.

Winthrop



If you don't have fluoride in your water...



...you should know about new Vi-Daylin® w/Fluoride with entrapped flavor

The evidence is in. More than 8,000 published reports verify the effectiveness and safety of fluoride as prophylaxis against dental caries. Yet most communities today are still without water fluoridation.

If you are in such an area, new Vi-Daylin w/Fluoride is an almost ideal means of supplementation for children. For three reasons:

1. Each tablet contains the equivalent of 1 mg. fluoride. This is the amount suggested for children three and over by the American Dental Association.*[1,2]

2. As in regular Vi-Daylin Chewable, your patient gets the benefit of *entrapped flavor*. This ingenious, double-coating process permits complete entrapment of raw vitamin tastes and odors—and keeps delicate flavoring oils fresh until the moment of use. Result: A tablet that tastes like citrus candy.

3. Sweetened with sugar-free Sucaryl®. Because Sucaryl is non-nutritive, it will not react with bacteria to form acids in the mouth.

Cost? No more than regular Vi-Daylin Chewable in economical bottles of 100.

75TH ANNIVERSARY ABBOTT

1. Prescribing Supplements of Dietary Fluorides, Council of Dental Therapeutics, J.A.D.A., 56:591, April, 1958.
2. Fluoride Compounds, Accepted Dental Remedies, 27th Ed.:139, 1962.

VI-DAYLIN w/FLUORIDE—Multivitamins with Fluoride. SUCARYL—Abbott's Non-Caloric Sweetener.

*In areas where drinking water is substantially devoid of fluoride.

104213



Relieves Anxiety and Anxious Depressio

The outstanding effectiveness and record of safety with which 'Miltown' (meprobamate) relieves anxiety and anxious depression has been clinically authenticated time and again during the past eight years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more than any other tranquilizer in the world.

Miltown®
meprobamate

WALLACE LABORATORIES / *Cranbury, N. J.*

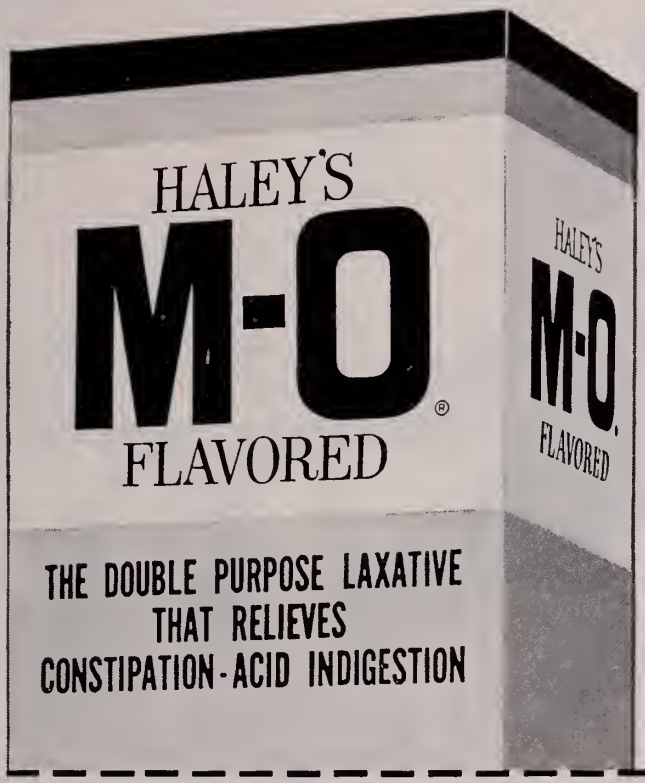
Product Information: 'Miltown' (meprobamate) indicated in anxiety and tension states, and all co ditions in which anxiety and tension are symptom in muscle spasm or tension; and in petit mal.

Slight drowsiness may occur with meprobama and, rarely, allergic reactions. Meprobamate m increase effects of excessive alcohol. Use with ca in patients with suicidal tendencies. Massive ov dosage may produce coma, shock, vasomotor a respiratory collapse. Consider possibility of depen ence, particularly in patients with history of dr or alcohol addiction. Withdraw gradually aft prolonged use at high dosage.

Usual dosage: 1 or 2 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coa d tablets; bottles of 50.

CM 9204

NOW ALSO IN **FLAVORED** FORM!



BOTTLES OF
4 OZ., 8 OZ.,
1 PT., 1 QT.

Antacid–Laxative–Lubricant to help correct constipation

Magnesium Hydroxide plus pure mineral oil make *Haley's M-O* a smooth working antacid-laxative-lubricant that efficaciously relieves constipation and attendant gastric hyperacidity.

The oil globules in *Haley's M-O* are minutely subdivided to assure uniform distribution and thorough mixture with intestinal contents. Oil leakage is thus avoided and a comfortable evacuation is effected through the stimulation of normal intestinal rhythm and blunted defecation reflex.

May we send samples for your evaluation? Just write:

THE CHAS. H. PHILLIPS CO.
Division of Sterling Drug Inc., 1450 Broadway, New York 18, N. Y.

to bring her back into balance

after menstrual irregularity



an orally active progestogen-estrogen combination

Duosterone®

anhydrohydroxyprogesterone . . . 10.00 mg.
ethinyl estradiol . . . 0.01 mg. } per tablet

Supplementing and supporting ovarian function, DUOSTERONE tablets can help release your patients from the anxiety, discomfort and inconvenience of functional amenorrhea and dysfunctional uterine bleeding.

DUOSTERONE therapy simulates and enhances the normal hormonal pattern of the secretory phase of the menstrual cycle, providing orally potent progesterone with ethinyl estradiol to prime the endometrium for adequate progestational response. Periodic progestational treatment with DUOSTERONE tablets aims at restoring the normal menstrual cycle—much as touching the pendulum starts a tightly wound clock.

Based on the classic studies of Zondek, Rakoff and others, DUOSTERONE provides dependable, trouble-free progestational therapy by mouth.

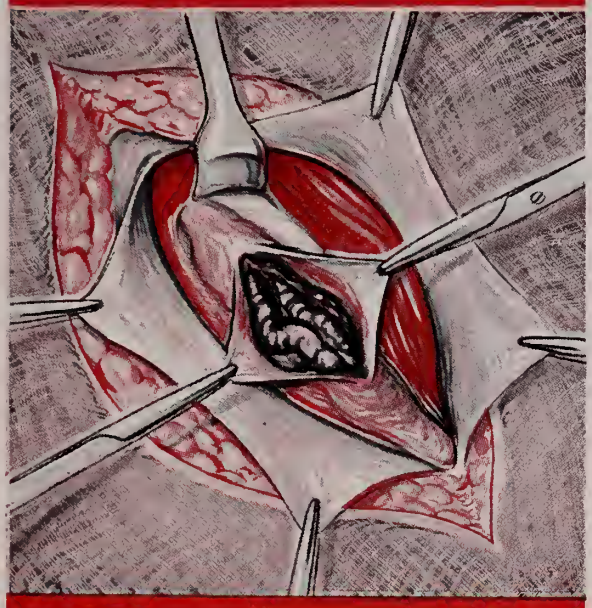
Bottles of 25 and 100 tablets with complete dosage instructions.

ROUSSEL

Roussel Corporation, New York 17, N.Y.

indication:

surgical trauma



Herniotomy

indicated:

Chymoral®

Enzyme Tablets

91% excellent to good results in 4,123 cases[1]

Chymoral (Enzyme Tablets) rapidly reduces postoperative edema . . . controls or eliminates inflammation . . . expedites absorption of exudates.[2-7] By hastening the absorption of blood and lymph from subcutaneous and muscle tissues, Chymoral (Enzyme Tablets) improves local circulation and reduces local pain. Patients experience less postoperative discomfort . . . require less analgesia.[2]

On rare occasions nausea, diarrhea, or mild skin reactions (hives, urticaria) have been reported. These symptoms subside promptly upon cessation of therapy. Safe use of Chymoral (Enzyme Tablets) in pregnancy has not been established. Although no adverse effects on clotting factors have been reported, these possibilities should be considered in treating patients having coagulation defects, such as hemophilia or afibrinogenemia.

The obvious advantages of oral therapy, coupled with virtual freedom from toxicity, make Chymoral (Enzyme Tablets) a valuable ally in surgery.

Formula: Each tablet provides enzymatic activity equivalent to 50,000 Armour Units supplied by a purified concentrate which has specific trypsin and chymotrypsin activity, in a ratio of approximately six to one. **Dosage:** Initially, two tablets q.i.d.; one tablet q.i.d. for maintenance.

1. Physicians' Reports to the Medical Department, Armour Pharmaceutical Company, 1961. 2. Malow, L.: Am. J. Proctol. *13*:249, 1962. 3. Teitel, L. H., *et al.*: Indust. Med. *29*:150, 1960. 4. Billow, B. W., *et al.*: Southwestern Med. *41*:286, 1960. 5. Beck, C., *et al.*: Clin. Med. 7:519, 1960. 6. Reich, W. J., and Nechtow, M. J.: J. Internat. Coll. Surgeons *36*:157, 1961. 7. Billow, B. W., *et al.*: Harlem Hosp. Bull., Annual Series No. 1, March, 1960, pp. 41-45.

The true economy of proven effective dosage

ARMOUR PHARMACEUTICAL COMPANY

KANKAKEE, ILLINOIS

Webcor Music Man

STEREOPHONIC HIGH FIDELITY TAPE RECORDER

...the ultimate in tape recorder performance!



PRICED AT only $198.80

- 2 and 4 track stereo operation
- 3 speeds—1⅞, 3¾, and 7½ ips.
- New, simplified "push-lever" operation
- Self-contained stereo record and playback
- Digital tape counter with pushbutton reset
- Dual volume controls—one for each channel
- Dual bass and treble controls

If you're the "one in a hundred" with a highly critical ear for perfection in sound, you'll be satisfied with nothing less than the new Webcor "MUSIC MAN" stereo tape recorder. And it's ever so simple to operate! Just push the lever up to "Play"... push it down to "Stop"... move it to the left to "Rewind"... to the right for "Fast Forward." Treat yourself to a thrilling new hearing experience. Ask for a demonstration today at—

Write for catalog to Exclusive N. J. Wholesale Distributors

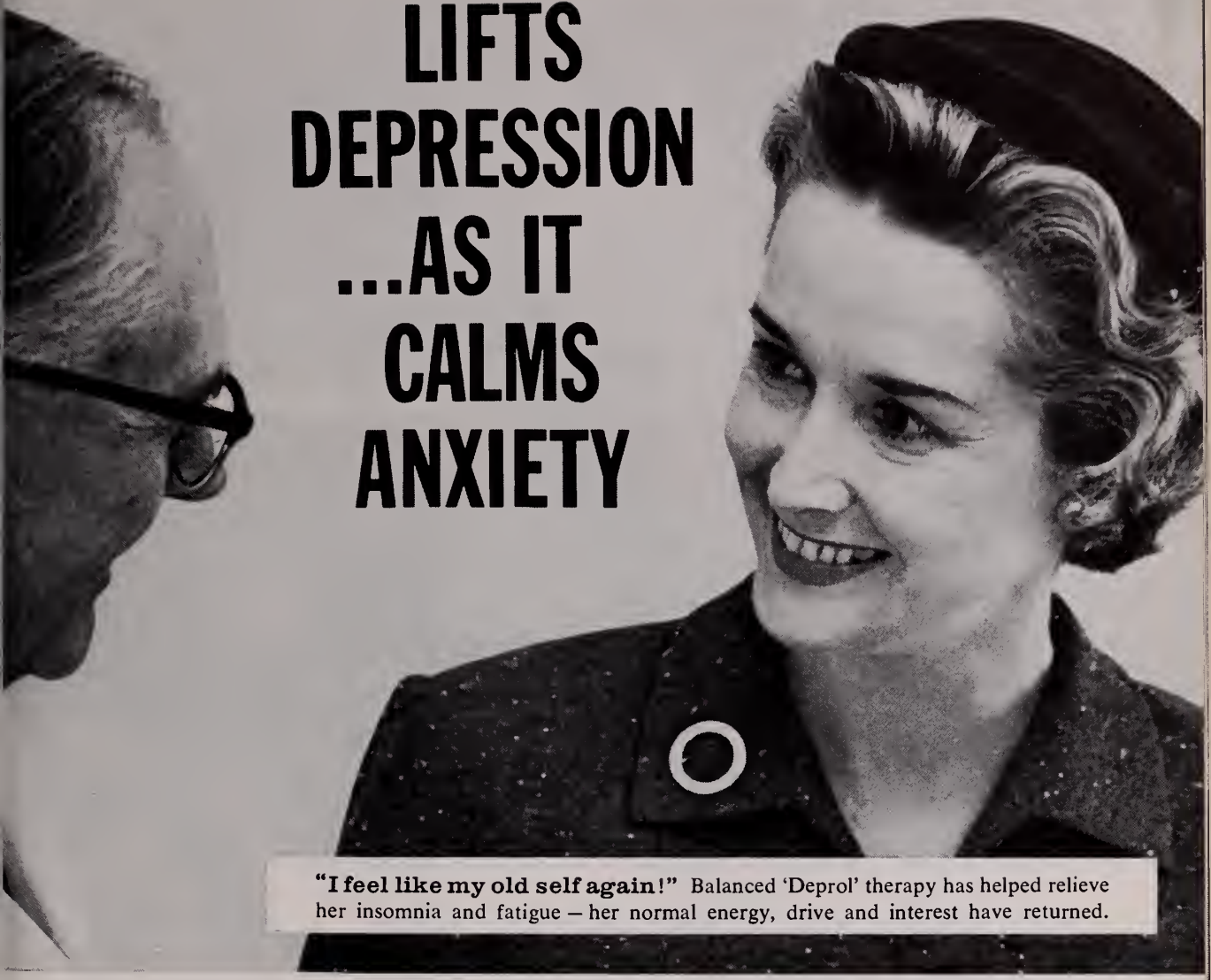
ALL-STATE DISTRIBUTORS

INCORPORATED

457 CHANCELLOR AVE. NEWARK, N. J.

WAverly 3-4900

LIFTS DEPRESSION ...AS IT CALMS ANXIETY



"I feel like my old self again!" Balanced 'Deprol' therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

Brightens mood...relaxes tension

Energizers may stimulate the depressed patient, but they often aggravate anxiety. Tranquilizers may help anxious patients, but they often deepen depression. 'Deprol' avoids these "seesaw" effects; it relieves both anxiety and depression.

Product Information: 'Deprol' is indicated for depression, especially when accompanied by anxiety, tension, agitation, rumination or insomnia. Slight drowsiness and, rarely, allergic reactions, due to meprobamate; and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

CO-9210

Usual Dosage: 1 tablet q.i.d. May be increased gradually, as needed, to 3 tablets q.i.d.; with establishment of relief, may be reduced gradually to maintenance levels.

▲Deprol▲®

meprobamate 400 mg. + benactyzine 1 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*





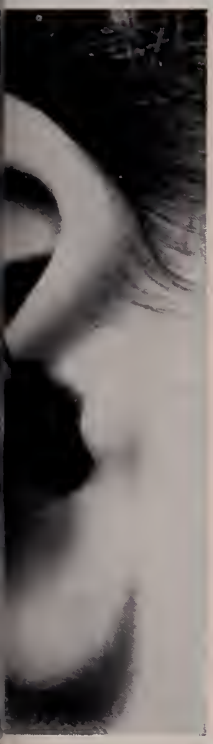


all things considered...the decision is for

in otitis media, having weighed the classi
cal considerations basic to management, physician
often choose DECLOMYCIN demethylchlortetra
cycline for broad-spectrum antibiotic therapy
DECLOMYCIN demethylchlortetracycline produce
activity levels higher than do other tetracyclines..
at lower dosage...and maintains them withou
significant fluctuation.

Activity is prolonged 24 to 48 hours after the las









DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE *syrup*

lose, thus helps protect against relapse—an "extra limension" in broad-spectrum control.

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. *Side Effects* typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction.

Contraindications: none.

Syrup, 75 mg. demethylchlortetracycline/5 cc. and *Pediatric Drops*, 60 mg./cc.

Average Daily Dosage—Infants and Children: 3 to 6 mg. per lb. body weight, in 2 or 4 doses.

EDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

PROFESSIONAL LIABILITY INSURANCE PROGRAM

officially endorsed by

THE MEDICAL SOCIETY OF NEW JERSEY

PROTECTION for Professional Acts and Professional Premises Liability for members of The Medical Society of New Jersey by the First American Liability Insurance Company.

LOSS CONTROL. Your County Medical Review and Advisory Committee will evaluate malpractice cases and recommend the action which would be most favorable for the Medical Profession, the Defendant Doctor, the Patient and the Public. This program permits understanding of the complex problems involved in such cases and calls for close cooperation between the Medical Profession and Insurance Company.

MEDICO-LEGAL FORMS are furnished to each insured doctor to help in reducing claims or dissatisfied patients. Failure to use forms does not affect the doctor's insurance coverage or his eligibility for insurance.

INSURANCE COUNSELING. Insurance counseling and advice, available at all times, without cost, to help you with your Professional Liability insurance problems.

CANCELLATION. No policy will be cancelled or non-renewed without prior consultation between your Society and the Company and this is a matter of complete cooperation for the best interests of all concerned.

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY

Policies Guaranteed Non-assessable

Professional Liability Department

123 CLEVELAND STREET — ORANGE, NEW JERSEY

Joseph A. Britton, Manager — ORange 3-2575

Home Office: Wakefield, Mass.

Trocinate®

Brand of Thiphenamil HCl.

FOR DIVERTICULITIS, MUCUS COLITIS,

IRRITATIVE DIARRHEA, IRRITATIVE URETERITIS,

BLADDER SPASM

*T*rocinate is a musculotropic antispasmodic with no appreciable anticholinergic action. It relieves spasms of the lower bowel and genito-urinary tract by direct action on the contractile mechanism of smooth muscles. The absence of any appreciable action on the autonomic nervous system eliminates the usual side-effects. It may be safely used in glaucoma. Each tablet contains 100 mgs. Trocinate HCl.

USUAL DOSAGE: 2 tablets, 4 times a day. Maintenance dosage is frequently lower.

Dispensed in bottles of 40 and 250 tablets.

WM. P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856

"Doctor... I'm so tired all the time"



Lethargic patients respond to Ritalin

(methylphenidate hydrochloride)

When lethargy is a medical problem—in convalescence, chronic fatigue, mild depression, menopause, oversedation, and senility, for example—the gentle stimulant action of Ritalin (methylphenidate hydrochloride) restores normal physical and mental activity.

In his report, Siegler[1] states: "In mild depression or in clinical exhaustion syndromes, a marginal sympathomimetic drug like methylphenidate seems to be the drug of choice for initiating therapy. It does not have the toxic effects found with the amphetamines or with the hydrazines or other antidepressants."

Other significant comments on the clinical safety of Ritalin (methylphenidate hydrochloride): "At no time was there evidence of serious toxic reactions [in a study of 185 patients]. The drug did not produce alteration in blood forming factors, kidney and liver function."[2]

"No significant toxic effects have resulted after the continuous administration of methylphenidate for more than 3 years."[3]

INDICATIONS: Chronic fatigue.

CONTRAINDICATIONS: Marked anxiety, tension, and agitation.

CAUTION: Should not be used to increase mental or physical capacities beyond normal limits. Use cautiously with epinephrine or levarterenol.

SIDE EFFECTS: Nervousness, insomnia, anorexia, nausea, dizziness, palpitations, headache, drowsiness.

DOSAGE: 10 to 20 mg. b.i.d. or t.i.d.

SUPPLIED: *Tablets*, 5 mg. (pale yellow), 10 mg. (pale blue) and 20 mg. (pale orange).

REFERENCES: 1. Siegler, P. E., in Nodine, J. H., and Moyer, J. H. (Editors): *Psychosomatic Medicine*, The First Hahnemann Symposium, Lea & Febiger, Philadelphia, 1962, p. 582. 2. Lapolla, A.: Western Med. *2*:383 (Sept.) 1961. 3. Yoss, R. E., and Daly, D. D.: Pediatrics *25*:1025 (June) 1960.

2/3098MB

C I B A SUMMIT, N. J.

Ritalin® hydrochloride (methylphenidate hydrochloride CIBA)



when allergens fill the air

Deltasmyl®

gives safer steroid protection from asthma

The aim of therapy in asthma should be relief of bronchospasm by means of decongestant and bronchodilating agents *plus prednisone.* When long-continued prednisone treatment is desirable, "the use of bronchodilator medication and other allied drugs should be continued *in order to decrease the dosage of the steroid hormone to a minimum.*" (Barach, A. L. and Bickerman, H. A.: Pulmonary Emphysema, Baltimore, The Williams and Wilkins Company 1956, p. 523.)

One DELTASMYL tablet provides the smallest, safest dose of prednisone (1.5 mg.), augmented by theophylline (120 mg.), ephedrine HCl (15 mg.), and phenobarbital (8 mg.), protects against asthma for about 4 hours. Not more than six tablets should be taken in 24 hours. Bottles of 50 tablets.

ROUSSEL — **Roussel Corporation,** 155 East 44th St., New York 17



Protect the kidneys and other threatened organs with Rautrax-N

SQUIBB STANDARDIZED RAUWOLFIA SERPENTINA WHOLE ROOT AND BENDROFLUMETHIAZIDE WITH POTASSIUM CHLORIDE

When treatment of hypertension is effective, the danger of damage to the renal system is reduced.[1,2] "Hypertensive patients suffer from vascular deterioration roughly proportional to the severity of the hypertension. ...Reduction of blood pressure to normotensive levels reduces or arrests the progress of vascular damage with a resultant decrease in morbidity and mortality. Among two comparable groups of patients with [nonmalignant] hypertension of equal severity, 72 per cent of those treated were still living after five years or more, while only 24 per cent of those not treated were alive at the end of this period."[1] *Because Rautrax-N lowers blood pressure so effectively, it will provide this important protection for your hypertensive patients.*

Rautrax-N—a combination of Raudixin, Squibb Standardized Rauwolfia Serpentina Whole Root, and the diuretic, Naturetin, Squibb Bendroflumethiazide—is effective in mild,[4] moderate[3,4] or severe hypertension.[3,5] It lowers blood pressure gently and gradually. And control of hypertension helps protect not only the kidneys but also the heart and brain from vascular damage.[2] For full information, see your Squibb Product Reference or Product Brief.

Supply: Rautrax-N—capsule-shaped tablets providing 50 mg. Raudixin, 4 mg. Naturetin, and 400 mg. potassium chloride. *Rautrax-N Modified*—capsule-shaped tablets providing 50 mg. Raudixin, 2 mg. Naturetin, and 400 mg. potassium chloride.

References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (4) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (5) Feldman, L. H.: North Carolina M. J. *23*:248 (June) 1962.

'RAUTRAX'®, 'RAUDIXIN'® AND 'NATURETIN'® ARE SQUIBB TRADEMARKS.

SQUIBB

Squibb Quality—the Priceless Ingredient

SQUIBB DIVISION Olin

throughout the wide middle range of pain — control with one analgesic* PERCODAN® *tablets

(Salts of Dihydrohydroxycodeinone and Homatropine, plus APC)

In a comprehensive range of indications marked by moderate to moderately severe pain, PERCODAN assures speed, duration, and depth of analgesia by the oral route... acts within 5 to 15 minutes... usually provides uninterrupted relief for 6 hours or longer with just 1 tablet... rarely causes constipation.



Formula — Each scored yellow PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone HCl (Warning: May be habit-forming), 0.38 dihydrohydroxycodeinone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. acetophenetidin, and 32 mg. caffeine. Also available: PERCODAN®-DEMI, containing the complete PERCODAN formula but with only half the amount of salts of dihydrohydroxycodeinone and homatropine. Both products are on oral Rx in all states where laws permit. **Average Adult Dose**—1 tablet every 6 hours. **Side Effects and Contraindications**—Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to acetylsalicylic acid or acetophenetidin and in those with blood dyscrasias. *Literature on request.* **ENDO LABORATORIES** Richmond Hill 18, New York

Endo®

*U.S. Pats. 2,628,185 and 2,907,768

BLUE SHIELD-



A RESPONSIBILITY!

New Jersey's 6,700 Participating Physicians have a responsibility to themselves and to the public to make Blue Shield an effective weapon in the fight for medical freedom.

Physicians participate in New Jersey's Medical-Surgical Plan because they have a firm belief in voluntary prepayment medical care. But it is not enough to just participate. Physicians must enthusiastically support the Blue Shield program . . . and to support it properly they must fully understand its problems, its objectives and its specific policies. And the physician who is fully informed has a responsibility to speak at every opportunity to patients, friends and the public about the tremendous potential of Blue Shield to provide an ever broader program of medical care prepayment by voluntary effort.

And the one New Jersey physician in five who has not yet joined Blue Shield can help to meet today's responsibility — by participation.



BLUE SHIELD®

Medical-Surgical Plan of New Jersey

500 Broad Street, Newark

Question:

"What is a tranquilaxant?"

Answer:

"A drug that is both a tranquilizer and a muscle relaxant."

TRANCOPAL®
brand of
chlormezanone
is a tranquilaxant

As a tranquilizer, TRANCOPAL (chlormezanone/Winthrop) "is effective in the symptomatic treatment of anxiety."[1] Its tranquilizing properties are similar to those of other mild tranquilizers.[1] Furthermore, it relieves tension of both mind and muscle without interfering with normal activity or alertness.

The muscle relaxant properties[2] of this drug provide an extra dimension of effectiveness...relaxing the spasm which so frequently accompanies psychogenic disorders. Hence, the total therapeutic effect of TRANCOPAL (chlormezanone/Winthrop)—a true "tranquilaxant"—is to produce a relaxed mind in a relaxed body.

Unsurpassed Tolerance: Less than 3 per cent of patients develop side effects with TRANCOPAL (chlormezanone/Winthrop), such as occasional drowsiness, dizziness, flushing, nausea, depression, weakness and drug rash. If severe, medication should be discontinued. In most patients, however, side effects are minor and do not necessitate interruption of treatment. There are no known contraindications.

Available: 200 mg. Caplets® (green colored, scored), 100 mg. Caplets (peach colored, scored), each in bottles of 100.

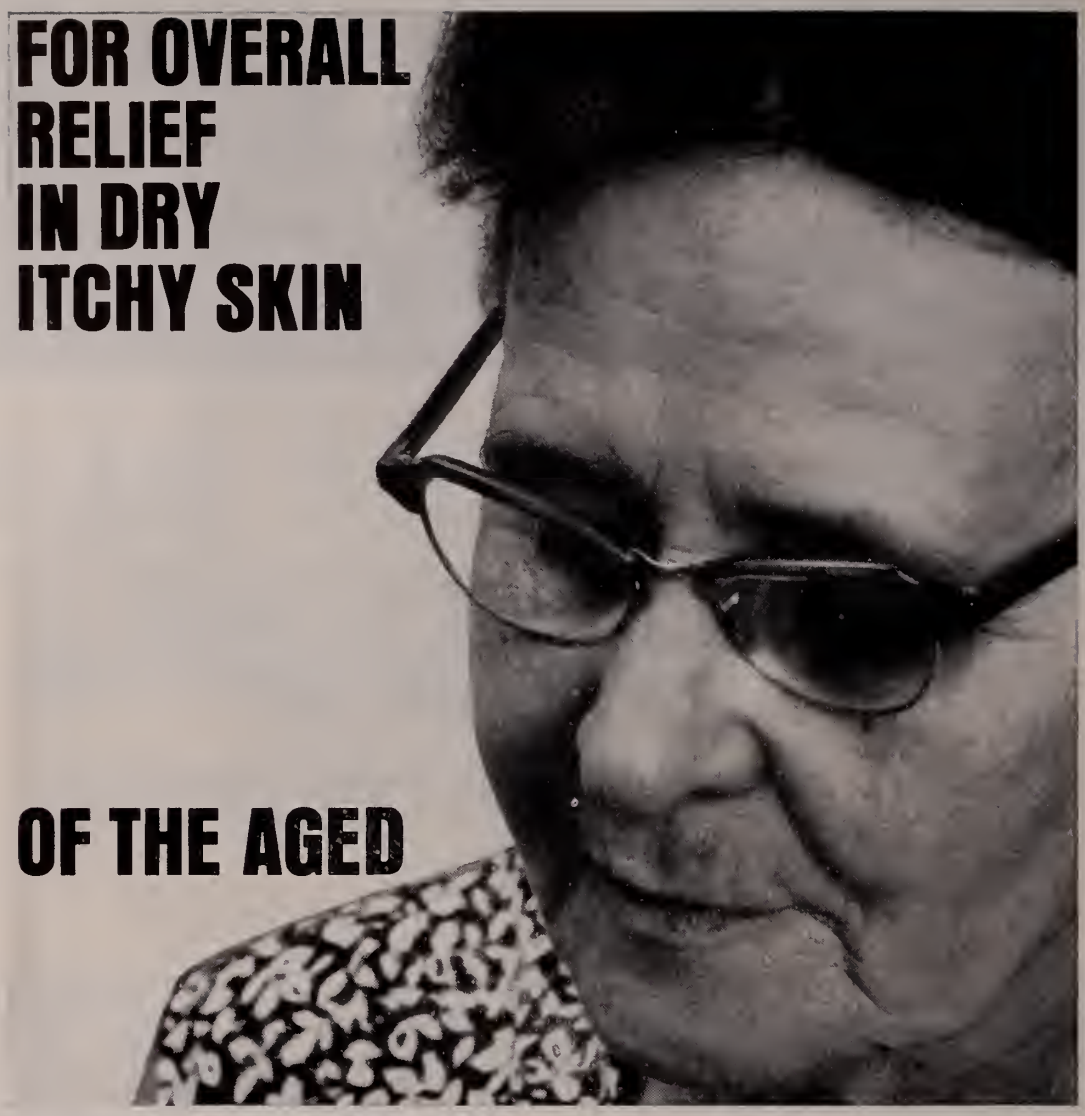
Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; in some patients 100 mg. three or four times daily suffices. Children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Winthrop
WINTHROP LABORATORIES
New York 18, N.Y.

References: 1. A.M.A. Council on Drugs: J.A.M.A. 183:469 (Feb. 9) 1963. 2. Gruenberg, F.: Curr. Ther. Res. 2:1 (Jan.) 1960.

1283M

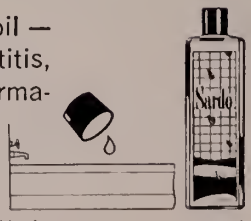
FOR OVERALL RELIEF IN DRY ITCHY SKIN OF THE AGED



SARDO® IN THE BATH

Borota and Grinell[1] found that SARDO baths rehydrate, relieve dryness, and promptly allay itching over the entire skin in elderly patients. A very fine lubricating film prevents undue evaporation of moisture—to help restore the normal lipid/aqueous balance of the skin, and keep it softer, smoother, more comfortable.

SARDO is the original high quality, superbly dispersible* bath oil—clinically proven[1-6] to allay xerosis and pruritus in atopic dermatitis, diabetic dry skin, eczematoid dermatitis, soap dermatitis, neurodermatitis, etc. Non-sensitizing, pleasant, non-sticky, economical.

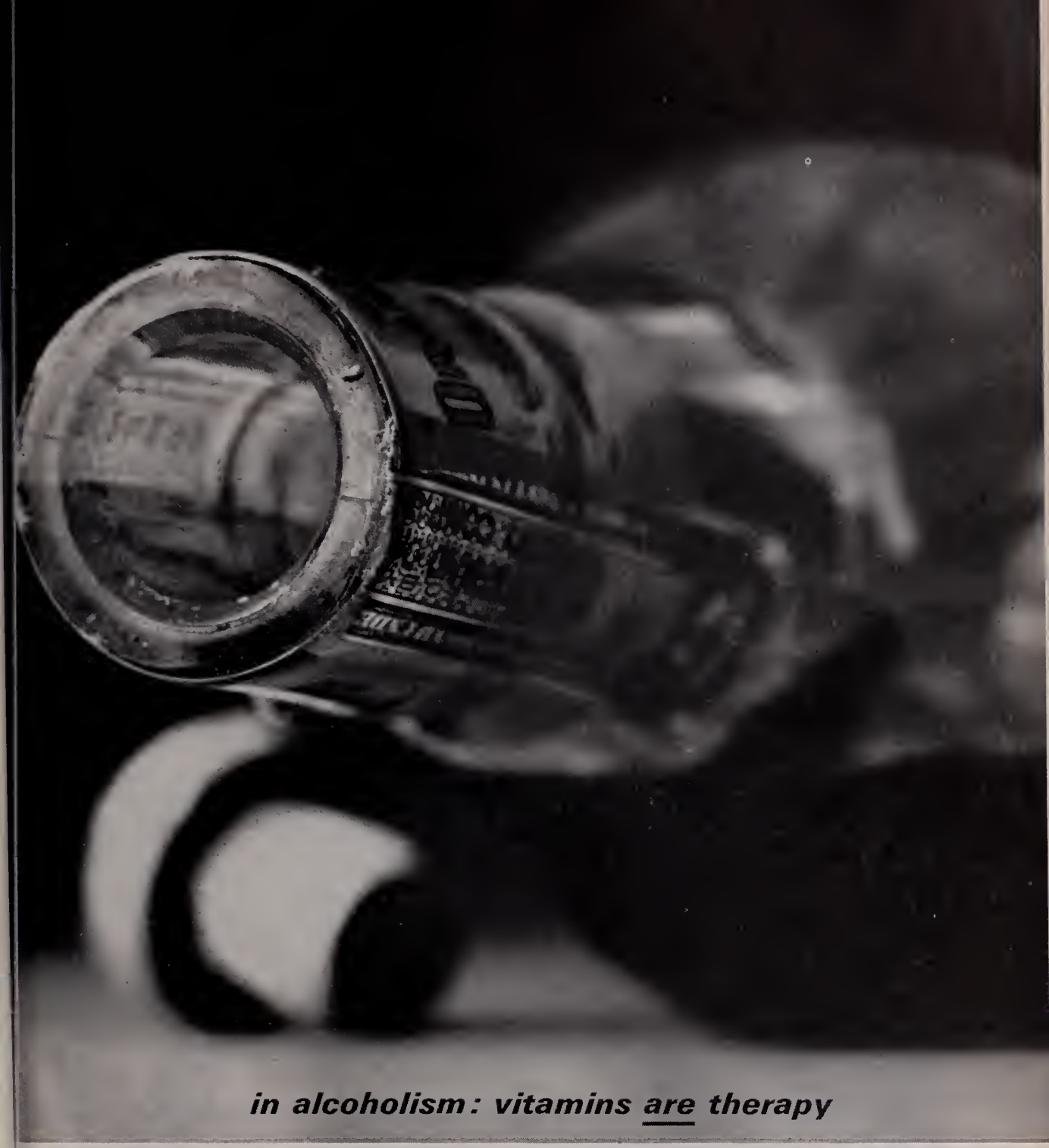


Bottles of 4, 8 and 16 oz.

SAMPLES and literature available from... SARDEAU, INC. 75 East 55th St., New York 22, N. Y.

1. Borota, A., and Grinell, R. N.: J. Amer. Geriatrics Soc., 10:413, 1962. 2. Spoor, H. J.: N. Y. State J. M., 58: 3292, 1958. 3. Lubowe, I. I.: Western Med., 1:45, 1960. 4. Weissberg, G.: Clin. Med., 7:1161, 1960. 5. Lieberman, W.: Amer. J. Proctology, 12:374, 1961. 6. Dick, L. A.: Skin, 1:341, 1962.

*Pat. Pend. T.M. © 1963 by Sardeau, Inc.



in alcoholism: vitamins are therapy

A full "comeback" for the alcoholic is partly dependent on nutritional balance... aided by therapeutic allowances of B and C vitamins. Typically, the alcoholic patient is seriously undernourished... from long-standing dietary inadequacy, from depletion of basic reserves of water-soluble vitamins.

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains: Vitamin B_1 (Thiamine Mononitrate)...10 mg. / Vitamin B_2 (Riboflavin)...10 mg. / Niacinamide... 100 mg. / Vitamin C (Ascorbic Acid)...300 mg. / Vitamin B_6 (Pyridoxine HCl)...2 mg. / Vitamin B_{12} Crystalline... 4 mcgm. / Calcium Pantothenate.. 20 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

6315-3

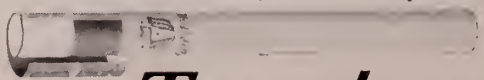
STRESSCAPS®

Hungry for flavor? Tareyton's got it!



Flavor you never thought you'd get from any filter cigarette!

You'll never know how satisfying filter smoking can be until you try Tareytons. Fine, flavor-rich tobaccos go into each Tareyton. Then the famous Dual Filter brings out the best taste of these choice tobaccos. Sound too good to be true? Pick up a pack of Tareytons today and see for yourself.



DUAL FILTER *Tareyton*

Product of The American Tobacco Company — "Tobacco" is our middle name

from the feet up—clears ringworm economically with half the dosage

Schering

fulvicin-u/f®

griseofulvin, ultra/fine, Schering

"Culture negative" after four weeks in this case of plantar tinea pedis

R. B., a 36-year-old writer, was first seen on November 5, 1962, with severe inflammatory tinea pedis involving the sole of the right foot. There was an 8-centimeter area of erythema, with vesicles, bullae and scales on the plantar surface of the foot. The lesion had been present for two weeks. Microscopic examination of scrapings showed hyphae, and cultures grew out *T. mentagrophytes.*

The patient was started on 0.5 gm. FULVICIN-U/F (griseofulvin, *ultra-fine*) daily. Three weeks later there was distinct improvement with only mild erythema and scaling present. After one additional week, therapy was discontinued and a second culture was negative. The patient was last seen on December 24, approximately three weeks after termination of therapy. At this time the skin was entirely normal in appearance.







1 Plantar tinea pedis before therapy.

2 After two weeks of therapy.

3 Six weeks later, skin essentially normal (two weeks after termination of therapy).

Clinical considerations: Although clinical studies with griseofulvin have not revealed evidence of serious toxicity, ***side effects***—as with any potent drug or antibiotic—may occur in some patients. An occasional minor decrease in leukocyte count has been observed, which was reversible when medication was discontinued. Occasionally, there may be heartburn, nausea, epigastric discomfort, diarrhea, lethargy, fatigue, psychomotor incoordination and, during the first week of therapy, headache. Studies are in progress to determine the safety of this drug during pregnancy; until the results of these studies are available, griseofulvin is contraindicated during pregnancy. ***Caution*** should be observed in patients with known penicillin-sensitivity. Should urticaria or drug rash develop, the drug should be withdrawn. ***Available*** in 125 mg., 250 mg. and 500 mg. scored tablets, bottles of 60 and 250.

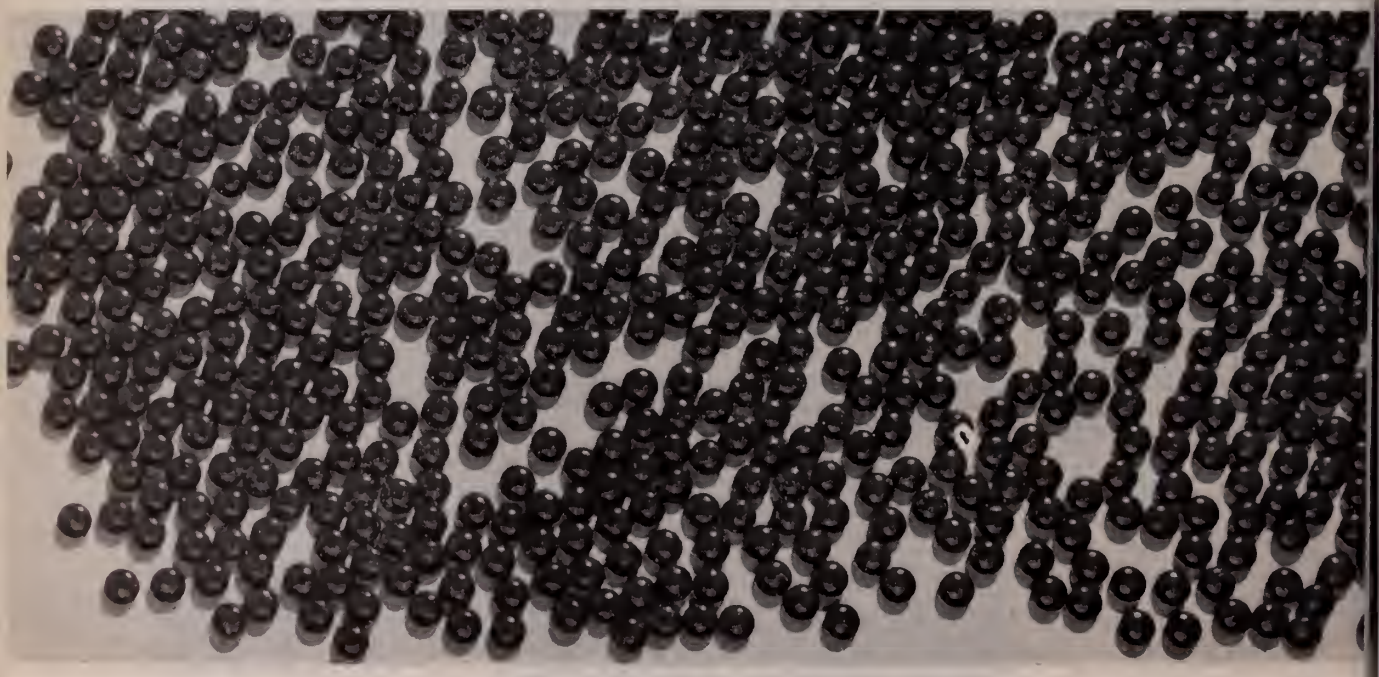
For complete details, consult Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey.

CASE HISTORY AND PHOTOGRAPHS COURTESY OF LEO R. LESE, M.D., NEW YORK, N. Y.

This is half an inspection



. . . this is the other half



Inspecting a coated tablet poses a two-sided problem: How do you make certain that both top and bottom are flawless without picking up each tablet and turning it? ■ We have a machine especially designed to do the job. The tablets pass along a belt under the watchful eye of an inspector. Any tablet that has the slightest irregularity in shape or coating is rejected. Then a second belt overrides the first and, holding the tablets tightly in place, turns them over and delivers them to another belt for inspection of the other side. ■ It is another in a long series of control measures designed to deliver quality pharmaceuticals every time.

Eli Lilly and Company • Indianapolis 6, Indiana, U. S. A.

Lilly

390079

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

See You On the Boardwalk

From the four corners of the nation they come to New Jersey. Doctors from Maine, Hawaii and Alaska, California and North Dakota.

It is hard to understand why any New Jersey physician would not attend this session in his own backyard. There are lots of reasons for going: Vacation. Relaxation. Renewal of old friendships. Participation in this great parliament of medicine.

And education. Don't forget that. As Dr. Fister, the AMA President, says, research men publish so much material now that it is often cheaper and faster to repeat an experiment than to search the literature and find out what others have done.

It would be necessary for a physician to read one book an hour just to keep up with new findings in his own specialty. Did you know that there were four million scientific documents published in 1962? These included three million papers and articles in seventy thousand journals. The bulk of these are in the life sciences, particularly medicine. They are published in 65 languages, in every sophisticated country in the world.

Faced with this overwhelming deluge of paper, the physician may be inclined just to throw up his hands. Here the scientific assembly comes to his rescue. At the AMA next month, in a short space of four days the physician has his choice of hundreds of scientific papers covering the vast spectrum of medicine. He can select half a dozen lectures daily from the program as a whole. Or he can concentrate on his specialty section and its meetings. He can see outstanding medical motion pictures, fresh from the production line. Or he can view live telecasts of surgery and medicine in action in new areas.

It would take years of reading an hour a day to learn all that can be learned at this annual meeting. The scientific exhibits alone constitute a good graduate course in medicine.

Next question!

Published Monthly Since 1904
Under the Direction of the Committee on Publication
Frank L. Rosen, M.D., Chairman

Henry A. Davidson, M.D., Editor
Theresa E. Goeke, Assistant Editor

Place of Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — EXport 4-3154
Each member of the Society is entitled to receive a copy of The Journal every month

Whole Number of Issues 705

Vol. 60, No 5 MAY, 1963 30 Cents - $3.00 per year

Blue Shield Success Story

Nearly 50 million of our fellow-citizens last year prepaid more than three-fourths of a billion dollars of their physicians' services through America's 70 Blue Shield Plans. And this vast volume of service was rendered at a cost of less than 10 cents on a dollar. Indeed, with only one exception, the operating expense ratio of U.S. Blue Shield Plans has been reduced every year since 1946, when less than two million people were enrolled in Blue Shield.

To some people, "nonprofit" operation implies inefficiency, high costs. Not so with Blue Shield, whose operating costs are the lowest in the business. Nonprofit in Blue Shield means that every salvable cent of the subscriber's dollar is utilized to provide the broadest possible scope of medical benefits. In a word, the "profits" of Blue Shield go to provide benefits to the Blue Shield subscribers, for whose benefit Blue Shield was created.

Every American physician should take pride in the success story of Blue Shield. It offers us, our fellow-citizens—and our government—a striking demonstration that American physicians, employers, workers, farmers, and all the rest of us, working together in a free society, can solve vast social problems by voluntary cooperation, without recourse to governmental assistance or domination.

Washington newspapers—please copy.

A Stop Street to Medical Research

When even the Society for the Prevention of Cruelty to Animals opposes an anti-vivisection bill, it should be obvious that the bill is a bad one. Congress has before it two proposals to limit the use of federal funds in research projects using animals. The bills provide for licensing of persons and laboratories engaged in animal experimentation under federal grants. The experimenter would be harrassed by demands for elaborate preliminary blue-prints, for detailed step-by-step records, and a requirement for federal permission for any change in procedure. Written into each bill is a provision for a new bureaucracy to police the laboratories. Special agents would be appointed who could enter any laboratory, scan its records, and put a stop to any study if (in the inspector's opinion) the project was not following its approved design. Under one of the bills, a Commissioner of Laboratory Animal Control would be appointed with the curious specification that no one could be named Commissioner who had done work in that field.

These proposals assume that experimental animals are now being brutally mistreated, an assumption that is insulting to the dedicated men and women who have devoted themselves to this work for years. The SPCA is opposed to these bills—and no one could accuse that Society of neglecting the welfare of animals.

Medical research would grind to a halt if it could not use living animals for experimentation. No progress is going to be made if experimenters have to work on inanimate objects or dead animals. It is a curiously morbid turn of mind that would prefer to see human beings die of disease rather than permit researchers to discover causes and treatment methods.

M. Idris, M.B.

R. Ryan, M.D.

P. Bazinet, M.D.

Trenton

Penetrating Abdominal Wounds in Day-to-Day Practice*

Perforating abdominal wounds are always serious, but the mortality has declined in the past forty years from 53 to 7 per cent. Dr. Idris and his colleagues discuss the reasons for this gratifying decline.

In recent years, the mortality due to penetrating wounds of abdomen have diminished markedly. During World War I, the mortality was 53.5 per cent. In World War II it was 25 per cent. In Korea, it had declined to 12 per cent. In several recent civilian series,[2] mortality due to penetrating abdominal wounds is quoted between 3.6 and 7.8 per cent. The decline in mortality is due chiefly to better management. Antibiotics also contributed.

We here present a case of penetrating abdominal wound and discuss the subject briefly in the light of recent literature.

A three-year old boy was hospitalized four hours after a spear had produced a penetrating wound of the left lower quadrant of abdomen. At the time of admission, hemoglobin was 10.5 Grams and hematocrit was 37. Temperature was 101.6. His pulse was 120. The abdomen was rigid and silent. About 5½ hours after injury, a laparotomy was done, revealing eight perforations of mid small intestine and three lacerations of mesentery of small intestine. Enterorrhaphies were performed for the perforations of small intestine. The mesenteric lacerations were repaired. The child was given antibiotics. Recovery was uneventful and he was discharged on the ninth hospitalization day.

In this case, the penetrating instrument was a spear. In any civilian population, the agents are usually shotgun, pistol, ice pick, butcher knife, rifle, switchblade knife and pocket knife. The mortality with shotgun wounds was the highest in a series of 494 cases of penetrating wounds of abdomen. More than 80 per cent were in males.

Individual Organ Injury

Most often, the small intestine is involved in penetrating wounds of abdomen. The liver is the next commonest site. Mortality due to injuries of duodenum and biliary tree is high. Low mortality figures (about 11 per cent) are quoted for the injury of liver, stomach, spleen, and small intestine.[4] The mor-

*From the Surgical Service of St. Francis Hospital in Trenton.

tality in injuries of abdominal aorta, vena cava and iliac vessels is very high: most victims die before they can get to a hospital. At times, multiple organs are involved. Abdominal signs might be completely masked by associated injuries elsewhere, such as head injuries or multiple fractures.

X-ray of abdomen is usually inconclusive in the diagnosis of injured organs. In perforation of the stomach or penetrating injury of colon, air was present in flat plate of abdomen in only 15 per cent of cases. X-ray, however, helps in localizing bullets or other missiles lodged in either abdominal wall or abdominal cavity.

MANAGEMENT

The treatment of hemorrhage and shock are the two essential factors in the management of penetrating wounds of the abdomen. The site of penetration in the abdominal wall gives a rough idea of the organs involved. If the patient shows signs of hemorrhage and impending shock, arrangement for blood transfusion should be made immediately. Before the blood is ready, the patient should be sustained by infusion of dextran or plasma expander. If injuries to gastro-intestinal tract are suspected a Levine tube should be passed. A catheterized specimen of urine should be obtained for analysis. Gross blood in urine suggests injury to the urinary tract. Simply filling the bladder with sterile water and getting back the same quantity of water, rules out perforation of the urinary bladder. Tetanus toxoid or antitoxin should be administered and the patient should be given antibiotics.

Most surgeons feel that exploratory laparotomy in penetrating abdominal wound is mandatory regardless of the extent of injury and the condition of the patient. A vertical incision is best suited for an exploratory laparotomy because of better exposure, easy extension (if necessary) and rapidity of performance. Peritoneal lavage should be done during surgery (and at the time of closure of abdomen) with copious amount of saline. Drains should be inserted.

Primary repair has been done in perforating injuries of colon with good results. In 144 primary repairs (done at Baylor University[3]) for perforating injuries of colon, the mortality rate was only 7 per cent. Two-layer closure of perforation of colon is advocated. If the whole circumference of colon is involved an end-to-end or side-to-end, anastomosis should be done after resection. Exteriorization is indicated if long segments of bowel have been destroyed, making repair difficult. In rectal lesions, proximal colostomy should be done.

Longitudinal defects of the ureter heal if the remaining circumferential wall at the site of defect contains all the components: serosa, muscularis and mucosa. Complete transection of the ureter should be anastomosed without tension.[6] Splinting of ureter avoids formation of stricture at the site of repair.

If the abdominal injury seems trivial, paracentesis abdominis may help in determining injury to liver or spleen by the presence of intra-peritoneal blood. The absence of blood at paracentesis, however, does not rule out injury to the liver or spleen.

No significant difference is noted in morbidity or mortality in penetrating abdominal wound treated within six hours and those treated over six hours.[7] An increased time lag often means a lower operative death rate. Peritonitis is caused by delay in operation; but the worst cases are also eliminated by the delay.

It is safer to do a needless laparotomy than to miss the chance to repair a remediable defect. Routine exploration, however, has a definite mortality and morbidity. In 494 cases of penetrating wound of abdomen,[7] mortality was 0.8 per cent in patients with negative laparotomy and 3.7 per cent in patients clinically diagnosed as without perforating abdominal wounds and treated without laparotomy. The application of trained surgical judgment rather than a set rule is the rational and intelligent approach to the management of abdominal injuries.

SUMMARY

A CASE of penetrating wound of abdomen with multiple perforation of small intestine is presented. Recent papers on the management of penetrating abdominal wounds are reviewed. The mortality rate has considerably decreased from 53.5 per cent during World War I, to 3.6 per cent in a 1962 study.[2] Primary closures of perforating injuries of colon are being done more and more.

601 Hamilton Avenue

BIBLIOGRAPHY

1. Wilson, H. and Sherman, R.: Wounds of the Abdomen. Ann. Surg., 153:639 (1961).
2. Goldman, L. I., De Laurentis, D. A. and Rosemond, G. P.: Penetrating Abdominal Wounds in a Civilian Population. Am. J. Surg., 104:46 (1962).
3. Roof, W. R., Morris, C. E. and De Bakey, M. E.: Perforating Injuries to the Colon. Am. J. Surg., 99:641 (1960).
4. Shafton, G. W.: Indications for Operation in Abdominal Trauma. Am. J. Surg., 99:657 (1960).
5. Gaston, B. H. and Mulholland, J. H.: Treatment of Abdominal Wounds. Surg. Cl. N. A., 35:463 (1955).
6. Weaver, R. G.: Principles of Ureteral Repair, Surgery, Gynecolgy and Obstetrics, 110:594 (1960).
7. Maingot, R.: Abdominal Operations. Appleton-Century-Crofts, Inc., New York, 1961. Ed. 4.
8. Economy, D., Koucky, C. and Novack, R. L.: Non-penetrating Injuries to the Spleen. Am. J. Surg., 99:646 (1960).

Surgical Care of Radiodermatitis

R. Parienti and co-workers, in the *Minerva Chirurgica* (Turin, Italy) December 15, 1961 issue, report on a surgical technic for the repair of occupational radiodermatitis of the hand. This consists in the excision of the tissues involved and replacement by free dermoepidermic grafts. The operation is performed under general anesthesia, but a local infiltration with procaine hydrochloride is given to simplify the dissection, reduce the hemorrhage, avoid shock, and make more visible any small cutaneous lesions. Of 12 such operations performed on orthopedists, radiologists, and surgeons in a 2-year period, 4 are described in detail and illustrated with photos and graphs showing different pre-operative and postoperative stages. The necessity of encouraging early movement of the operated hand, so as to prevent articular rigidity, is stressed. It is also pointed out that in spite of the development of scientific knowledge about radiation, the risk of injurious effects is still great in the professional use of x-rays.

Is the Cadaver Shortage Ending?

In its March 1962 issue of *Events*, the National Society for Medical Research (Rochester, Minnesota) reports that two national magazine articles and a syndicated newspaper column have produced a flood of inquiries from persons all over America who want to bequeath their remains after death for medical use. Anatomy department chairmen report receiving as many as 500 inquiries apiece. The NSMR* office receives up to 250 each day. Several medical colleges have asked the NSMR* to "cancel the order" for a while at least.

The demand for information has exhausted two printings of Dr. Oliver P. Jones' booklet, *How to Donate Your Body for Medical Science*. A third printing is in process.

*National Society for Medical Research, 111 Fourth Street, Rochester, Minnesota.

William C. Giordano, M.D.

Ridgefield

One Application Treatment for Tinea Versicolor

If subsequent studies confirm Dr. Giordano's findings we should be able to eliminate tinea versicolor completely.

This preliminary report has been prompted by a recent paper by Zimmerman [1] describing a new agent for tinea versicolor. Most authorities [2,3,4] say that the treatment of tinea versicolor has been unsatisfactory; it is unpleasant and is usually followed by recurrences.

I am here reporting on 19 patients with tinea versicolor treated by me with selenium sulfide. They came from my private practice of internal medicine and were not seen primarily for their skin conditions. For this reason many patients are irretrievably lost in the files. However, 19 cases have been resurrected out of a total of at least 70 cases. These 19 ranged in age from 12 to 66 years. Duration of disease varied from one to 30 years. Each patient had had only temporary or incomplete control of the lesions with previous medications.

Their treatment was the same in each case. After a hot bath, a 2½ per cent selenium sulfide suspension was applied to the affected parts with gentle rubbing, in the evening before retiring; and was allowed to remain overnight. The following morning, it was removed by bathing or showering.

In all cases, the rash disappeared within a week after this one application.

Pityriases (tinea) versicolor is a benign, non-contagious superficial fungus infection of the skin caused by *malassezia furfur*. The characteristic macular eruption usually affects the neck and trunk but may involve other parts of the body. The color varies from pink to light brown. After tanning from sunlight, it appears white and is slightly scaly. It is most common under conditions of heat and moisture. It is found in almost 50 per cent of people in the tropics. In temperate climate, it affects up to 10 per cent of the population in the summer months. Clinical diagnosis is not difficult. And the organisms can be identified in scrapings with potassium hydroxide ink stain. Many applications have been recommended: sulfur, salycilic acid, resorcinol (alone and in combination), saturated solution of sodium thionsulfate, benzoic and salycilic acid, tincture of iodine, chrysarobin, calomel ointment, and many others, with only temporary results or with sensitization of the patients.

Recently, Zimmerman [1] used 9-amino-acridinium 4-hexylresorcinolate with good results in 39 of 40 cases. He reported recurrences in seven of these. Only one had poor results. However, this treatment required four to eight weeks. Zimmerman was not aware (nor was I, until preparation of this paper) that selenium sulfide had been previously used for tinea versicolor. Robinson and Yaffe [5] used 1 per cent selenium sulfide cream on 28 patients. Treatment then consisted of two daily anointments of the body for two weeks with baths every three days. They found no recurrences after one year

of observation. Here again treatment lasted two weeks and was time consuming and inconvenient. The following personal experience describes the first use of this medication (by accident) and my subsequent experience with many other patients.

For 36 of my 51 years, I have been an unwilling host to the fungus tinea versicolor. All the standard treatments recommended by various authorities were tried with only temporary or incomplete results. Five years ago, when a hot summer had caused a particularly heavy infestation of the disease, I found myself without any of the usual remedies. For no good reason (probably because of its sulfur content) I decided to use a 2½ per cent selenium sulfide suspension in a buffered emulsifying base.* This was applied to the affected areas on retiring and the following morning was removed by showering. I then forgot about it until some weeks later. Then I noticed that all the lesions had disappeared! Since that time, this one dose treatment with 2½ per cent selenium sulfide has been used on the 19 patients with identical results. Recovery after one treatment! There has been no recurrence in any of these 19 patients.

The final conclusion about this treatment must, of course, await large scale controlled experiments by individuals who have access to large groups of patients with this condition.

Selenium is present in high concentration in the soil of the Dakotas, Kansas, Montana, and Wyoming.[6] Cattle sometimes develop gastrointestinal symptoms and liver disease. At 0.2 milligrams a day (the actual intake by humans in this area) there is no toxicity.[7] The element is deposited in all tissues, including the liver. (It would be interesting to determine whether residents of this area are immune to tinea versicolor.)

There is no absorption from the skin or mucous membrane, but the compound is irritating to the eyes. Flech[8] tried to determine the mode of action of selenium sulfide in seborrhea and concluded that it was due to the inactivation of free sulfhydril groups in the skin. Whether this is the reason for its action in tinea versicolor remains to be seen.

SUMMARY

Evidence suggests that 2½ per cent selenium sulfide suspension is a convenient, inexpensive easily used remedy that appears to clear up tinea versicolor after one application. Further large scale testing is needed to confirm or deny these early findings. If effective, this treatment can be expected to eradicate this troublesome but otherwise harmless skin disease.

*I used the Abbott brand tradenamed Selsun® which is marketed for the control of dandruff, not tinea.

948 Maple Avenue

BIBLIOGRAPHY

1. Zimmerman, E. H.: Journal of the American Medical Association, 176:23 (April 8) 1961.

2. Pittsburg, D. M., Shelley, W. B. and Kligman, A. M.: *Dermatology.* Philadelphia, 1956, Saunders. p. 578.

3. Sulzberger, M., *et al.*: *Dermatology.* Chicago, 1961. Year Book Publishers. Ed. 2, p. 313.

4. Andrews, A.: *Diseases of the Skin.* Philadelphia, 1954, Saunders. P. 309.

5. Robinson, H. M. and Yaffe, S.: Journal of the American Medical Association, 162:113 (September 8) 1956.

6. Grollman A. and Slaughter, D.: *Cushney's Pharmacology.* Philadelphia, 1957, Lea & Febiger. Volume 13.

7. Smith, M. I., Westfall, B. B. and Stohlman, E. F., Jr.: Public Health Report 52:1171, August 27, 1937. Also; same authors: Journal of Pharmacology and Experimental Therapy, 60:449 (August 19) 1937.

8. Flech, P.: Journal of Investigative Dermatology, 21:233 (October) 1953.

George G. Salmon, Jr., M.D.
Short Hills

Margaret Symonds, M.B., B.S.
New Vernon

Staphage Lysate Therapy in Chronic Staphylococcal Infections

Exceptionally good results are here reported in the use of a specially prepared staphylococcic antigen for the control of chronic staphylococcic infections.

Staphylococcal infections continue to be prevalent. An ever-increasing number of reports of staphylococcal disease appear in the scientific, medical, and (perhaps more significantly) the lay press. Elek[1] states, "In fact, by sheer weight of numbers and distribution, staphylococci are the most widespread of all human pathogens." These infections are difficult to treat because of the frequent emergence of antibiotic-resistant strains, particularly in hospital patients. It is now noted that antibiotic-resistant strains are increasing in the general population. This is the basis of the present-day alarm. As each new antibiotic is developed, its use is followed remorselessly by the appearance of insensitive strains[2] of staphylococcus. It is of greatest importance to find out the factors governing host susceptibility and resistance to staphylococcal colonization and infection. Host resistance is of prime importance in preventing infection with these ubiquitous organisms.[3] All means by which this resistance can be increased must be welcome additions to our armamentarium.

Over the course of the last nine years, the senior author has increasingly used in his pediatric and pediatric allergy practice a staphylococcal antigen prepared by the lysis of virulent staphylococcal cultures. It is the purpose of this paper to present the results of this therapy to date.

CASE MATERIAL

The cases forming the subject of this study are grouped here according to the location of the staphylococcal infection or according to the anatomic diagnosis as follows: furunculosis; pustular acne; pyodermia; eczema; bronchial asthma (intrinsic or bacterial); staphylococcal intestinal involvement and upper respiratory infection (U.R.I.). Regardless of whether the patient had one or more localized areas of infection, or a more generalized infection, colonization of the host with staphylococcus pyogenes was the basic condition.

Each case of staphylococcal infection included in this study was either selected from a regular pediatric practice or was a member of the family of a pediatric patient and was treated at some time between January 1954 and June 1961. Antibiotics were usually tried before the start of staphylococcus bacteriophage lysate therapy.* Most patients received

courses of tetracycline, penicillin, chloromycetin, and a sulfa derivative. Very few did not receive three of these drugs in separate series prior to SPL* treatment.

FOLLOW-UP

THE cases presented here in summary were all available for follow-up. Effort was made to locate the physician of each patient who had moved away or changed doctors. These physicians were asked for brief summaries of the patient's condition. Patients thus reported were included in this study.

BACTERIOPHAGE LYSATE

STAPHYLOCOCCUS bacteriophage lysate† is prepared from broth cultures of virulent strains of coagulase-positive staphyloccocus aureus, belonging to serologic Type I and Type III, which have been lysed by staphylococcal bacteriophage. These strains were originally obtained from human clinical lesions. The SPL* consists of these lysates together with live staphylococcal bacteriophage. No preservative is added. Bacterial sterility is obtained by the use of excess bacteriophage and filtration, and maintained by strict aseptic technic. The product contains lysed staphylococcus cell wall material, staphylococcus intracellular substances rendered soluble by the lytic process, the metabolites and enzymes elaborated by the staphylococcus, culture media ingredients in which the staphylococci are grown and living staphylococcal bacteriophage. Thus, this product contains a full representation of the antigenic components of the staphylococcus without any preservative which may denature the proteins.[4]

ADMINISTRATION

ONCE the nature of the infection is established, the patient is given a series of SPL* treatments. From 1954 to July 1959 all doses were given intranasally. Children less than two years old were given an instillation applied directly to the nasal mucosa by medicine dropper daily by the parent at home. Adults and children over two years old received nasal instillation of SPL* by aerosol apparatus,† fitted with sinus adaptors.† Treatments were given one to three times each week for five or six weeks unless improvement was noted earlier. Following this course, if symptoms recurred, two or three further treatments were given.

In July 1959 work was completed that indicated that SPL* was safe for injection. When the product was licensed by the National Institutes of Health, the work was reviewed by the authors, and new subjects were given SPL intradermally or subcutaneously in graduated doses. These cases are also included in this study.

DOSAGE SCHEDULE

THE dosage schedule was arranged to produce the desired result without causing excessive systemic or focal reactions.

SPL-I* is usually given alone at first. The initial dose is 0.05 or 0.1 cubic centimeters and successive doses are double the previous dose unless excessive reaction is noted. When a full cubic centimeter is reached, SPL-I and SPL-III are started at 0.1 cubic centimeter doses and volume increased as with the SPL-I alone. Frequency varies from every other day to weekly until the full dose is reached. Thereafter, monthly intervals are usually maintained. However, if an acute inflammatory process occurs while the prolonged interval is maintained (and if that process is thought to be due to staphylococcic infection) two or three doses are often given at two-day intervals.

No anaphylactic reactions have been reported by or to the manufacturers.

CASES TREATED

FORTY-EIGHT patients in our series had *furuncles and abscesses* due to staphylococcus (Group 1). Their ages ranged from one week

*Hereafter SPL is used for Staphylococcus bacteriophage lysate therapy.

†Material was produced and marketed by Delmont Laboratories, Inc., Swarthmore, Pa. The aerosol apparatus was a Vaponefrin® Nebulizer. The sinus adaptor was a DeVilbiss® Tr-40.

Group	of the Infection Nature	Cases Treated	No. Recoveries	%	No. Improvements	%	No. Failures or Relapses	%
1	Furunculosis	48	48	100	0	0	0	0
2	Pustular acne	14	11	79	3	21	0	0
3	Pyodermia	24	24	100	0	0	0	0
4	Eczema	60	52	86	7	11	1	2
5	Bronchial asthma	34	30	88	2	6	2	6
6	Respiratory infection	409	304	76	98	23	7	2
7	Intestinal disorders	18	17	94	0	0	1	6
	Total	607	486	80	110	18	11	2

to 62 years. The one-week-old infant's mother was known to be chronically infected by staphylococcus. This new-born child (who developed a breast abscess) was started on SPL* therapy as soon as fluctuation was determined. Most of the patients in this group had been given antibiotics or sulfa drugs before starting SPL.* Those who developed boils while on SPL therapy for other staphylococcal conditions were not given other treatment. These lesions usually cleared within a few days.

Duration of symptoms before the start of treatment varied from nineteen years to one day. Twenty-eight were three months or less in duration; ten between three months and one year; five between one and five years; and five between five and 20 years. Twenty-four cases cleared after from one day to six weeks of treatment. Sixteen cleared after six weeks to six months of treatment. Four cleared after six months to one year. And the remaining four were symptom-free after they had been given treatment for periods up to 19 months.

In the 48 cases, there was not one single failure. All the patients have remained free of of boils for a follow-up period of seven months to four years.

Fourteen patients who had *pustular acne* were treated (Group 2). The first four patients who had acne and who received SPL therapy* were being treated for chronic recurrent sinusitis. They had flare-ups of chronic acne during the treatment. When these flare-ups subsided, the skin of each patient was free of pustules or of reddened indurated areas. It was apparent they had recovered from the acne. This encouraged us to treat ten other patients who had severe acne. Each patient had previously undergone extensive treatments with other agents. They were discouraged people. Of this group, seven recovered completely and three showed improvement. Of these three, one had received severe x-ray burns of the involved area. Her acne was much better, but she has required more frequent injections to boost her immunity than did any other patient in the practice reported.

Twenty-four cases of persistent *pyodermia with purulent weeping infected eczema were treated.* (Group 3). These varied in duration of symptoms preceding SPL* treatment from three months to nineteen years. Each patient was given SPL for from two weeks to six months. In this group there were no failures: each patient recovered. No localized inflammations, and no areas of purulent eczema remained. One who had lesions for 19 months before treatment, experienced nausea, depression, and dizziness after seven treatments. These symptoms were so severe that she left our care. However, her skin cleared two weeks after stopping the treatment and has been clear 18 months, ever since her last treatment.

Sixty cases of *eczema* were treated with SPL therapy (Group 4). In some, the eczema became severe at the time of acute infections. In others, the eczema was thought to be due to bacterial sensitivity because of repeated improvement on antibiotic therapy. Some in this group were being treated for other manifestations of their staphylococcal infections. Duration of symptoms before the start of treatment varied from one day to fourteen years.

Fifty-two cases are free of eczema and have remained free during the follow-up period which varies from four years to seven months. Seven of the eight remaining patients are im-

proved. One is an adult who had dry, cracking eczema of the hands for 14 years. She was given SPL* therapy for nine months and has shown marked improvement, and has maintained this improvement for two years. One has had treatment for brief periods at irregular intervals for eight years; his lesions recur, and he returns for one or two treatments that help him enough so that he seeks our aid at each return of symptoms. Another, an infant, had a generalized weeping eczema and improved, but left our care after eight weeks; it is reported by others that there are two large areas of persistent dry, scaly eczema. While this patient was obviously improved, it is the question whether time or other factors may be credited for her improvement, as well as this therapy. Four are considered improved, but not cured. The sixtieth patient in this group illustrated a difficult problem that has occurred during the use of SPL therapy. This was a 15-year-old girl with eczema of the face, trunk, and antecubital fossae, as well as in the popliteal spaces; this has been severe for 13 years since she was one year of age. Therapy was started in this case with very small doses intranasally. However, she became acutely ill on starting treatment. Her lesions became worse (as is expected), but she also experienced abdominal pain and elected to discontinue treatment. These reactions confirmed to us the etiologic role of staphylococcus. Had smaller doses been given, milder side effects would not have discouraged her and she would have tolerated continuation of therapy. However, the rare severe reaction does not seem to justify starting all patients on minute doses.

Thirty-four patients were treated for chronic recurrent *bronchial asthma* (Group 5). These usually had fever with each asthmatic attack which was not seasonal. Antibiotics seemed to increase the effectiveness of conventional asthma therapy, thus indicating (together with the almost invariable appearance of coagulase positive staphylococcus in throat and nose cultures) the bacterial etiology. The duration of symptoms before the start of SPL therapy ranged from one month to 21 years. Average duration was three years. However, the mode duration was considerably shorter.

The interval from the first treatment to the recovery varied as in other types of diseases caused by staphylococcus and treated with SPL.* Recoveries, when they did occur, took place in from a few days to 20 months.

Thirty patients have been observed to be symptom-free for a period from eight months to four years with no recurrences. These patients are considered as having recovered. Two patients are considered improved. One child (lost to follow-up after 13 months of treatment) was improved when last seen. A 14-year-old boy had asthmatic bronchitis and asthma since 15 months of age, and had asthma with each cold which recurred at intervals of a few weeks until the start of SPL* therapy. He now experiences mild expiratory wheezes with these colds which recur on the average only twice a year. These two patients are considered improved. Two patients, one child and one adult, showed no change and have continued to wheeze as they did before treatment.

Four hundred and nine patients who had *chronic upper respiratory Infections* were treated (Group 6). They are frequently designated as chronic sinusitis, chronic tonsillitis, chronic laryngitis, chronic bronchitis, chronic otitis media, as well as chronic upper respiratory infection. This arbitrary differentiation is based on criteria too personal and too flexible to be of much value; so they are described here together under the general heading 'U.R.I.' Four or more acute exacerbations in a six-month period was considered to characterize a "chronic" illness.

The nose and throat cultures grew coagulase positive staphylococcus persistently before SPL* therapy in almost all these patients. (Phage typing was not done.) After treatment, 304 of the 409 patients had only one or two illnesses each year, and no longer had persistent or chronic symptoms following each acute illness. These patients are considered as having recovered. Ninety-eight have had fewer attacks and were generally better between acute episodes. These are called "improved." Of the remaining seven patients (listed as unimproved because the symptoms persisted) three are worth noting. In one, staphylococcus was no longer recovered in nose and throat cultures after treatment; yet he failed to improve clinically. One continues to have "sinus

headaches" after treatment, but now these headaches occur during the pollen season only. In one case, our conclusions are unreliable, since he received cortisone for rheumatoid arthritis during the therapy. The effect of antigen therapy is uncertain when given concomitantly with steroids. The other four continued to have repeated febrile and upper respiratory infections with nasal discharge.

Eighteen patients who had *intestinal symptoms* were treated (Group 7). Symptoms varied from three weeks to 27 years' duration before start of SPL therapy.* Many were selected for SPL therapy because they had or gave a history of frequent staphylococcal infections, usually furuncles or abscesses, in the past; and had shown repeated, brief periods of improvement on antibiotic therapy. Some had positive staphylococcal nose, throat or skin cultures at the time of onset of therapy. The symptoms varied from three weeks to 27 years' duration before the start of therapy. Fourteen with the following diagnoses were treated; chronic diarrhea; mesenteric lymphadenitis; nonspecific intestinal allergies (these patients were being treated for other symptoms of staphylococcal infection). All these patients have remained symptom-free. These 14 patients are listed as having recovered.

Three adult patients with *ulcerative colitis* diagnosed elsewhere were treated. They all had positive cultures of staphylococci from the stool. These patients showed improvement. Two experienced recurrences of old staphylococcal infections of the skin during treatment; one of these infections was a severe acne that had been quiescent for years. This acne ran a short course and the patient rapidly showed marked improvement of both the acne and ulcerative colitis. This patient was one of the first four acne cases treated. The other case developed an acute cellulitis of the foot. The original foot infection had occurred 20 years previously and was then called a fungus infection. The cellulitis subsided with some difficulty, but the patient has remained free of both cellulitis and of colitis symptoms since the acute episode.

One child under ten years of age had ulcerative colitis. He showed some temporary improvement with this and the other therapies tried. He eventually went to surgery and died.

COMMENT

BURKY[5] experimented with rendering rabbits sensitive to low ragweed, by uniting the weak antigen with staphylococcal toxin achieving the hypersensitive state. He observed that "It is probable that substances with little or no antigenic activity will become antigenic when combined with or attached to the (staphylococcal) toxin radical . . . At this time it is not clear why staphylococcal toxin alters the antigenicity of ordinarily inert substances. However, the result reported here, and other experiments which have been done all point to the fact that it has the ability to increase antigenicity." This probably accounts for the fact that some asthmatics will have positive skin tests to a variety of inhalants, but become symptom-free on antistaphylococcal therapy without further desensitization to the inhalant antigens,[6] and also the occurrence of eczema and similar lesions during treatment. Prigal[7] in his discussion of asthma and infection underlines the *contagion* factor, and suggests that intrafamilial staphylococcal infection may be responsible for the 'inheritance' of asthma rather than a genetic mechanism.

The mode of action of SPL* in no way resembles that of antibiotics or chemotherapeutic drugs, nor even the direct "phage" action as tried by D'Herrelle and other early workers. It is a specific vaccine, requiring a period of time to bring about an immune response. As all the patients treated had been chronically sick with long standing staphylococcal infections, the initial dose, if given during an acute episode, did, in fact, often bring about an early response (in most instances within four to 12 hours). These situations may represent accelerated immune responses. In fact, all human subjects have previously been exposed to staphylococcal antigen.

UNTOWARD EFFECTS

A FREQUENT accompaniment of staphylococcal disease is hepatic enlargement with a soft, sometimes tender liver. This was frequently seen on selected patients and it was

also observed during the early stages of SPL therapy. Hepatic function tests (thymol turbidity and cephalin flocculation) of these patients during this state, and at repeated intervals, subsequently revealed no impairment.

No renal damage has been shown. Pyuria, present at the onset or occurring during therapy, either cleared up rapidly without the aid of antibiotics and other means of treatment or was discovered to be of nonstaphylococcal origin. Sometimes flare-ups of previously dormant infections occurred, becoming apparent, presumably, by the death of the contained bacteria, and subsequent liberation of their intracellular toxins. For this reason, it is particularly important to obtain a careful history as a guide that certain reactions specific to that patient may be anticipated.

Some patients experienced unpleasant effects from the inflammation at the site of old infections, and malaise often accompanied this. No alarming or untoward reactions were experienced among the 607 patients, some of whom received intensive therapy with amounts of SPL* up to seven cubic centimeters a week in doses of one cubic centimeter daily subcutaneously, or two cubic centimeters by aerosol† three times a week. No anaphylactoid reaction has occurred, and no case of serum sickness has been experienced.

CONCLUSION

A TOTAL of 607 cases of chronic staphylococcal infections were treated. Four hundred eighty-six recovered; 110 were improved, and 11 were not helped. The patients who recovered were under SPL* therapy for varying periods of from a few days to 20 months. The "improved" cases were treated longer, and these patients returned for further treatments from time to time. The "unchanged" cases were treated for shorter periods than those who indicated improvement or went on to recovery. In most, the course of the disease with SPL* therapy has been a decreasing duration of each episode of infection together with a decreasing frequency of occurrence of such episodes with a final marked improvement in the patient's general condition, or a complete recovery.

The authors are well aware of the many unanswered problems of the interaction between staphylococcal pathogenicity and host resistance. But we believe SPL therapy* to be a valuable step forward as an immunization procedure against staphylococcic infection "on the basis of an informed empiricism and clinical experience."[8]

SUMMARY

1. SPL therapy* was used in 607 cases of staphylococcal infections. Eighty per cent recovered, 18 per cent improved and two per cent were unchanged.

2. SPL was used as an antigen to stimulate production of antibodies.

3. No ill effects of therapy were observed except temporary discomfort.

We acknowledge the cooperation of Margaret L. De Ward, B.Sc., whose technical help made this paper possible.

415 White Oak Ridge Road

BIBLIOGRAPHY

1. Elek, S. D.: *Staphylococcus Pyogenes.* Edinburgh, 1959, E. S. Livingstone, Ltd.

2. Jevons, M. P.: British Medical Journal, 1:124 (February 1961).

3. Elek, S. D.: Annals of the New York Academy of Science, 65:85 (1956).

4. Boger, W. P. *et al.*: Proceedings of the Society of Experimental Biology and Medicine, 104:639 (September 1960).

5. Burky, E.: Journal of Allergy, 5:466 (September 1933).

6. Symonds, M. E. and Salmon, G. G., Jr.: *Lancet*, December 16, 1961, Letter to the Editor.

7. Prigal, S. J.: *Fundamentals of Allergy,* New York, 1960, McGraw-Hill.

8. Mudd, S.: Journal of the American Medical Association, 173:1361 (July 23, 1960).

Charles M. Thompson, M.D.

Philadelphia, Pa.

The Interpretation of Abdominal Pain*

Pain is the prime symptom which sends the patient to a doctor. In this compact monograph, Dr. Thompson gives practical pointers on the interpretation of abdominal pain.

Two important pathways transmit pain to the chest from the upper abdomen. These are the nerves of the sympathetic nervous system, the splanchnic nerves; and the phrenic nerve. The vagus has no importance[1] except for occasional reference from the esophagus to the nerve of Arnold or as it indirectly initiates pain mechanisms by hyperfunction.[2] See Figure 1.

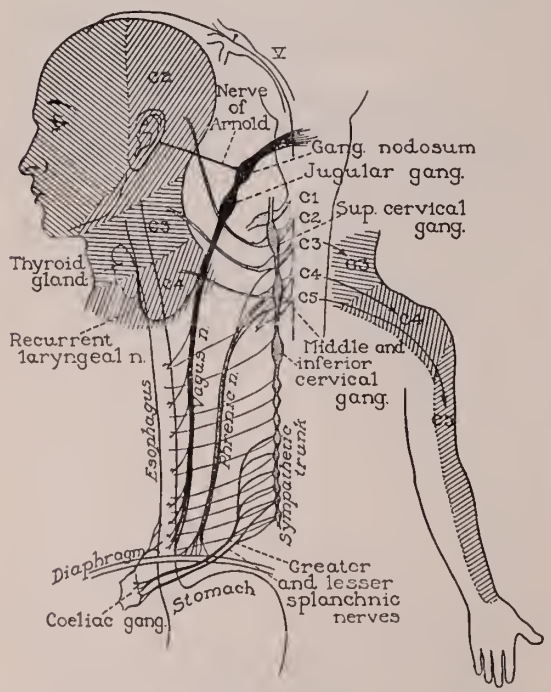


Figure 1.

Visceral pain is felt in the midline unless there is massive intensification of the pain sensation (when it overflows, and is called *summation pain*); or unless there is peritoneal irritation or penetration, when it *lateralizes*. It will be seen from Figure 2 that lesions of the abdomen causing chest pain are more likely to be in the stomach, duodenum, gall-bladder and ducts. This schematic representation does not include the important pathway from the pancreas. Another, resident in the splenic flexure, will be discussed. It will be noted in the upper-shaded area that there often is no discriminating separation of pain sensation in the epigastrium, the subxiphoid zone or the lower chest zone.

The phrenic pain pathway is important. Figure 1 reveals its ramifications. The phrenic nerve innervates the inner zone of the diaphragm affected by disorders or lesions of the esophagus (and high stomach), or in rare instances from irritation of an aberrant branch of the phrenic nerve in the hepatoduodenal ligament affected by diseases of the gall bladder, the common duct or of the duodenum. Phrenic pain radiation can simulate cardiac pain radiation.[1] There is a subtle and often obscure difference. Phrenic pain, when radiating to the hand, approaches the radial side in contradistinction to cardiac pain which almost always reaches to the ulnar side.[2]

Disorders of the esophagus lead the list in causing chest pain. In the order of frequency,

*Read by invitation May 14, 1962 at the Annual Meeting of The Medical Society of New Jersey.

these disorders are (1) reflux esophagitis or hypertonic sphincter; (2) hiatus hernia; (3) tumor; (4) ulcer; (5) achalasia; and (6) diverticulum.

Up-to-date appraisals of function at the lower esophagus recognize the importance of a sensitive functional sphincter and of reflux. A whole new study is being directed to a syndrome of chest pain with a hypertonic esophageal sphincter and reflux of gastric acid material into this zone.

Leading the list in actual statistical incidence (and, paradoxically, belonging at the end of a list of actual diagnostic incidence) is reflux esophagitis with or without hypertonic sphincter. Also important is the hypertonic sphincter syndrome which may exist without esophagitis.[3]

Reflux, inflammation or hypertonic sphincter may co-exist with hiatus hernia. It is possible with reflux and chronic inflammation in this area to develop shortening and gastric herniation. Of all the types of hiatus hernia, the sliding type and the short esophagus type are more likely to be associated with chest pain.

Any esophageal tumor, benign or malignant, may present with chest pain. In benign tumor, the chest pain is associated with dysphagia and is relevant to it. The chest pain from esophageal causes is a multiple result of food passing through an obstructed area; through an inflammed or hypertonic area; or of penetration and extension. The first two are perceived more commonly through the phrenic pathway or rarely the vagus pathway; and the latter more commonly through the thoracic sympathetics; an identical pathway for the perception of heart pain. Somatic or sympathetic pain occurs in penetrating and extending malignant tumors.

Ulcers of the esophagus (which are uncommon) are most likely to be found in a herniated stomach, in junctional areas in a hernia, or in aberrant tissue. They have a great tendency to penetrate and to bleed. They are refractory to medical treatment.

Achalasia frequently begins with chest pain. This is in the early stage of the tapering spindle; before the stage of proximal decompensation.

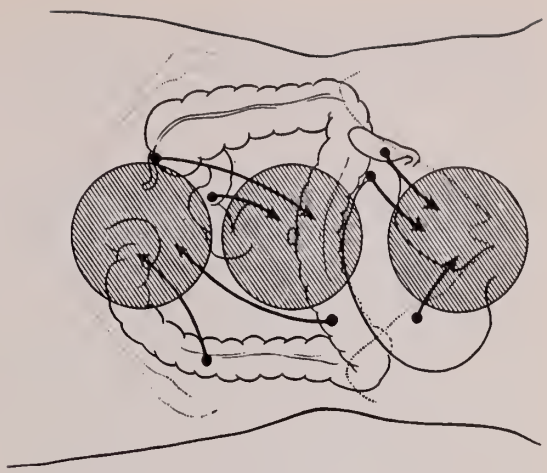


Figure 2.

It is rare for a diverticulum of the middle esophagus to be the cause of chest pain.

Clinical characteristics of esophageal pain that most often have differentiating value are listed. Recumbency leads this list and explains both the high incidence of night pain, and the importance of advising no recumbency for at least three hours after a meal in these patients. It is surprising how often the association of bending over or slouching in a soft chair or auto seat for long periods triggers the pain of both hernia and of the syndrome of reflux, esophagitis and hypertonic sphincter. Only a few other conditions can give pain in the chest with recumbency. These include dissecting aortic aneurysms, osteolytic lesions of the spine, angina with congestion and auricular myxoma.

Dysphagia is rare in cardiac or pulmonary disorders except where aortic aneurysmal dilatation or bronchogenic carcinoma cause compression. It is almost unheard of in left auricular chamber enlargement, even when this causes marked radiographic evidences of esophageal compression.

When dysphagia occurs it is very common for the patient to "put his finger on it." In guiding the history a practical question or directive is to ask the patient to put his finger on the spot where the food sticks. In more than half of the times this will be identical with the area of radiographic abnormality.

Regurgitation is most likely to occur with recumbency, particularly after the heaviest meal. This may produce night coughing or alarming choking spells.

The most common lesions of the esophagus presenting with regurgitation are diverticula of the cervical esophagus, hiatus hernia, achalasia and tumor. All but the first of these can be associated with *chest* pain.

The location of pain is usually at or near the site of the disorder. Since the commonest disorders occur at the lower esophagus, this is the epigastrium, the subxiphoid area or the area of the lower chest in the mid-zone. Radiation of the pain follows the phrenic pathway, the thoracic sympathetic pathway to front and back of chest or, to a region skirting the left lower rib cage.

Many of these characteristics are intangible and their identification will depend upon both x-ray demonstration and the use of newer instruments (See figure 3). These include perfusion and measurements of tone.

This is a radiographic representation of an indwelling esophageal tube measuring the pH at a particular level in the esophagus.

The pathways for pain reference in gastric and duodenal ulcer are again the splanchnics: T-6 to T-9. Any role the vagus plays is indirect,[1] and depends upon vagus activity increasing secretion and tonus.[2]



Figure 3.

HIGHLY positioned ulcers, particularly of the deep penetrating type, can produce more anterior chest pain than others. However, the pain reference does not depend upon position alone. Frequently, because of intensity of pain, their is summation or overflow of pain reference to the chest. This is particularly true when anxiety is present. In a few cases with deep penetration of a duodenal ulcer involving the hepatoduodenal ligament, where abberant phrenic nerve filaments may be present, pain is referred to the chest and right shoulder. Changes in the esophagus associated with duodenal ulcer, varying from reflux to spasm to inflammation, can in themselves induce chest pain with a high degree of ulcer activity.

Differentiation in the ulcer group is perhaps more easy than in the esophagus group. There are three standard measurements, or criteria, for ulcer activity: rhythm, recurrence and response. The last two are more reliable criteria than rhythm. Rhythm is too often poorly recognized or evaluated. Too many syndromes without ulcer have a rhythm that is not distinguishable. Ulcer disease loses rhythm when penetration occurs. The pain pattern then becomes perverse, as it is often critical and isolated and *worsened* by the ingestion of food.

Heart pain can be induced by a heavy meal or can follow at a measurable interval after a meal, simulating even the meal to pain relationships of an active ulcer.

The obscure syndrome of esophagus reflux and hypertonus, though more likely to be marked by critical anterior chest pain, may infrequently have a rhythm that in part depends upon gastric hyperfunction and reflux. However, none of these will show the actual high *seasonal recurrence rate* or the usual immediate response to a strict ulcer regimen that holds for uncomplicated ulcer no matter what its position.

The pathway for pain perception in the

chest from disorders of the gall bladder[1] and ducts is still the splanchnics[4] T-6 to T-9.

The mechanisms are three. They are first, *distension* which, experimentally produced, is either of the duct or the fundic organ and can produce both chest pain and abnormalities in the electrocardiogram.[4]

The second and third are *inflammation* to the serous coat and penetration or *perforation* beyond this barrier. When these more grave changes have occurred there is diffusion of pain perception and original simple chest reference is overshadowed.

No one has settled the perennial controversy of aggravation of heart changes by disease in the gall bladder. Suffice to say that there *is* factual overlap and co-existence. Pain, due to active gall bladder disease, may have chest reference because of the intrinsic innervation or because it induces more ischemia in an already damaged heart. That co-existence is often the rule and not the exception, prompts the observer to integrate some degree of heart disease in the older patient with overt gall bladder disease. In this group of patients it is an invariable practice to include heart work-up before surgical intervention and to consider both heart disease and gall bladder disease in the middle-aged patient with distress in the epigastrium or the anterior chest after the heaviest meal.[4] The proneness of gall bladder disease or duct disease to manifest isolated critical attacks of pain is helpful in differentiating from ulcer but not so helpful in differentiating from heart attacks.

The causal relationship to the heaviest meal, no matter what its fat content (and to occur from two to four hours after it) *is* helpful. The absence of effort pain is often distinguishing.

In practice the great difficulty arises in distinguishing acute passive congestion from gall bladder inflammation. This is so real a problem in the evaluation of abdominal pain with chest reference in the older patient, that rarely is immediate cholecystectomy practiced as often as it is preached. In this evaluation there is room for thoughtful observation with nothing by mouth and repetitive differential white blood cell counts. The differential white blood cell count will often show a marked shift to the left in obstructive or suppurative cholecystitis.

THE pathway for pain perception in the anterior chest from diseases of the pancreas is both the splanchnics[1] and short spinal nerves of the lumbar plexus.[2] Those conditions of clinical importance include acute pancreatic edema, pancreatic necrosis or pancreatic tumor. The severest pain starts in the short spinal nerve roots that partly innervate the organ, and because of intensity of pain, there results overflow or summation up and down the spine over internuncial stations. This peculiar result is illustrated by the frequent simulation of pleurisy with acute pancreatitis. The splanchnic pathway participates in the chest reference.

Another reason for anterior chest pain, in pancreatic disease is necrosis, or hypovolemia and myocardial ischemia. This may produce evidence of subendocardial ischemia on the electrocardiogram. This may become so difficult a point of differentiation that only an elevated serum amylase will separate myocardial ischemia *with* shock from myocardial infarction *and* shock. A serum calcium determination may be very utile in just such a situation.

We have found an incidence of thromboembolism, approaching 30 per cent, in malignant tumors of the body and tail of the pancreas. These were in all sites, both peripheral and visceral. However, one-half of these involved the heart or lungs. This is a factual co-existence. It does point up another cause for chest pain in pancreatic disease.[5]

An anatomic fact that has a relationship to pancreatic pain and chest references is that splanchnic fibers decussate to the pancreas. Most of the right splanchnic goes to the right side of the gland and the left splanchnic to the left side. However, a considerable portion of the branchings decussate so that each side receives some of its innervation from the opposite splanchnics.

I believe that the clinical characteristics of pancreatic pain aiding in the differential diag-

nosis are well known. A few of these are referred to briefly.

Wide diffusion of pain is often present. This includes reference to the chest and marked scattering of pain in the whole abdomen.

Radiation to the back is well known. Less well known is radiation to the anterior chest, especially to the left lower chest. This may be due to the splanchnic innervation or due to intensity of pain overflowing in the cord to the thoracic segments that innervate the chest wall.

In a middle-aged male with indefinite pain, often referred to the back and to the anterior chest wall, resemblances to heart pain are disquieting. However, when that same patient complains of physical weakness out of all proportion to physical evidences and manifests a peculiar downgrading of mood, this evidence fits best a malignant tumor of the pancreas.

One cannot speak of abdominal causes for pain without referring to the ubiquitous functional group. Abdominal discomfort or pain with chest reference occurs in the magenblasse† syndrome and the irritable colon syndrome. The magenblasse† group are more overtly aerophagic and betray their identity by noisy and demonstrative eructations. The splenic flexure group with an irritable or hypertonic colon are not so demonstrative or easy to detect.[6] And it has been said [6] that aerophagy is the most common cause of abdominal discomfort with distension. At least a half of these "compulsive air swallowers" have anterior chest discomfort simulating, at times, cardiac disorders.

The combination of anxiety with hyperventilation with aerophagy is recognized by the physician for what it is. This clear distinction by the physician is not so readily recognized by the patient who will associate the symptoms with heart disease.

The irritable colon syndrome with its particle, the splenic flexure syndrome, occurs in any adult age group. Its frequent occurrence in the older patient who has had coronary occlusion or myocardial failure, compounds the difficulties of differential diagnosis.

Figure 4 illustrates psychologic pathways for the development and continuance of this disturbing situation.[5] There is a cause for anterior chest pain from alterations in coronary flow that is often unrecognized or missed. This is not uncommon on the wards of a city hospital in the aged patient.

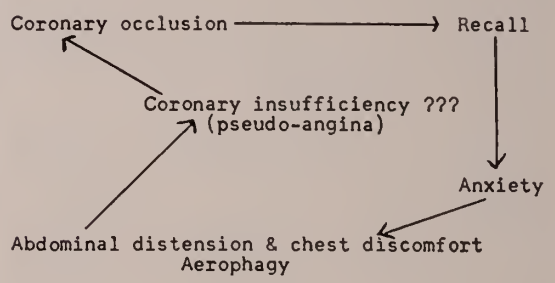


Figure 4.

Unrecognized gastro-intestinal hemorrhage may cause hypovolemia and myocardial ischemia. There may be no show of blood, or measurement of blood loss, for hours or even to death. The electrocardiogram may show ischemic changes, without transmural infarction.

CONCLUSIONS

THERE are more frequent cardiac or pulmonary causes for abdominal pain than there are abdominal causes for chest pain. This is the best reason for modest delay in the older patient who may have gall bladder disease or heart disease or both.

Co-existence is more real in diseases of the chest and abdomen than it is in international relations. It is probably more important than disease interrelations.

Frequently it is necessary to utilize a time period to observe both the acute case and the chronic case to separate abdominal from chest causes. This separation depends primarily upon recitation and re-examination of historical relationships, and secondarily depends upon the use of ancillary measurements.

†Magenblasse is the German for "stomach bubble." It is the radiographic shadow of a collection of gas in the upper part of the stomach—a dark area above the light shadow of the opaque meal.

If time to observe allows, the repetitive or serial use of certain studies are better than a single determination of them.

Evaluation of the electrocardiogram in a patient with severe pain due to intra-abdominal causes requires careful reflection on the ischemic changes produced by shock and pain.

The complementary usefulness of a spread of tests is illustrated by the case with fulminating pancreatitis. The electrocardiogram may show S-T segment changes and arrhythmia. The diagnosis may be aided by a high serum amylase. However, severe necrosis of the pancreas may show a normal or low amylase. In this situation the blood calcium is often low.

Overlap in causes for anterior chest pain coming from the digestive tract results from proximity, as in the esophagus or high stomach lesion; from intimate splanchnic innervations; from reflex and reflux, and from summation or overflow over spinal connecting pathways. Half the battle is won by recognizing that there *is* an overlap. From this point we can be better prepared to apply the twin disciplines of historical recording and nondelaying observation with ancillary study.

255 South Seventeenth Street

BIBLIOGRAPHY

1. Gray, H.: Anatomy of the Human Body. Ed. 23. Philadelphia, 1961, Lea & Febiger.

2. Symposium on Pain from the Upper Part of the Abdomen. Proc. Staff Meeting, Mayo Clinic. July 29 (1953).

3. Code, C. F., *et al.*: Hypertensive Gastroesophageal Sphincter. Proc. Staff Meetings, Mayo Clinic, July 6 (1960).

4. Bellett, S. and Stroud, W. D.: Interrelationships of Cardiac and Gastro-intestinal Disorders. Bockus *Gastroenterology*, Vol. 3. Philadelphia, 1952, Saunders.

5. Thompson, C. M. and Rodgers, L. R.: Analysis of the Autopsy Records of 157 Cases of Carcinoma of the Pancreas with Particular Reference to the Incidence of Thromboembolism. American Journal of Medical Science, Vol. 223, 469, 65:126 (May 1952).

6. Roth, J. L. and Bockus, H. L.: Aerophagia: Its Etiology, Syndromes and Management. Medical Clinics of North America, Vol. 41, 1671 (December 1957).

7. Personal observations with D. Berkowitz.

British Health Service

The popular hunger for sociologic facts on services which touch everyone, such as the National Health Service, is not matched by the quality of the fare. An analysis of the criticisms in 1961 of Jewkes, Lees, Seale, etc., which gained wide publicity indicates the bases of their conclusions as slender. The wholly economic approach to the N.H.S., which is not a monolith, but a complex of personal services whose form, development, and performance depend on social, political, and moral forces, is unrealistic. Above all, the arguments are inadequate and often contradictory. In most countries the patterns of health services are in key with the social and fiscal arrangements, but despite differences in organization, in Western civilized societies, the fundamental problems facing health services are roughly similar and the effect of the structure is marginal. In most criticisms of the N.H.S. there is lack of appreciation of the real issues. The author contends that its main defects arise from shortfalls in morale, intellectual discipline, education, understanding, social behavior, which are only too common in most modern societies and enterprises. The N.H.S. is not an experiment but the established order in the United Kingdom, and there never has been a proper evaluation of it.

Gordon McLachlan, *Lancet*, 1:312, February 10, 1962).

Herman H. Tillis, M.D.

East Orange

A New Therapy for Osteoporosis*

If subsequent studies confirm this survey, methandrostenolone would appear to be an extraordinarily effective therapy for the increasingly common disorder known as osteoporosis.

Since the average life span of our population is now over 70, the numbers of elderly have increased. As a result, osteoporosis has begun to receive renewed interest and emphasis. Recent studies[1] indicate that many osteoporotic patients have an increased sedimentation rate, signifying true destruction of tissue. Therefore, one can think of osteoporosis as a continuous process of increased irritation over a number of years, with bone destruction as an end result.

Osteoporosis is an important disease, more common than most physicians generally realize.

Early manifestations of osteoporosis are unclear or difficult to interpret. Most patients with early osteoporosis express a vague feeling of discomfort in their backs. This progresses in severity. They may complain of nocturnal cramps and present symptoms of so-called "postmenopausal fibrositis" with subcutaneous nodules in the fascia of the arms and legs.

The simplest way to recognize osteoporosis (long before it can be detected clinically) is by x-ray, especially in the small bones of the hands and feet.

Osteoporosis may be defined as a deficiency of calcified bone due to a defect in the formation of bone matrix. It has many graduations of severity. In milder cases, symptomatology may be as vague as in myositis and fibrositis. As the disease progresses, pain becomes prominent and x-rays may reveal compression fractures of the vertebrae.

Serum calcium and phosphate concentrations are usually normal in osteoporosis. Calcium is absorbed into the blood stream, but pours through the bone like water through a colander. The function of an anabolic agent in therapy is to promote protein synthesis in the bone. This produces deposits of calcium in the bone, plugging the holes in the colander.

The most common causes of osteoporosis:

(1) Menopause (natural or surgical)
(2) Disease of immobilization
(3) Senility
(4) Prolonged treatment with ACTH or steroids
(5) Malnutrition
(6) Rheumatoid arthritis

Many women over 50 years of age show roentgenographic evidence of osteoporosis.[2] Lack of estrogen and androgen are important factors in the postmenopausal and senile types. The anti-anabolic or catabolic action of cortisone may account for the development or presence of osteoporosis during prolonged steroid therapy.

RATIONALE OF TREATMENT

The protein catabolic effect of adrenocorticoids is associated for the most part with

*This work is from the Arthritis Department of United Hospitals of Newark (Presbyterian Unit).

1. Kuzell, W. C., Glover, R. P., Bruns, D. L. and Gibbs, J. O.: Geriatrics, 17:428 (July, 1962).

2. Ludwig, G. D. and Elsom, K. O.: Amer. Practit., 12:77 (February, 1961).

an accelerated conversion of amino acids to glucose.[3] These catabolic changes are indicative of varying degrees of protein depletion, which are evidenced clinically by progressive loss of body weight, ecchymosis, striae and osteoporosis.[4]

Albright and Reifenstein[5] established the hormonal basis for the treatment of osteoporosis. According to these authors:

"The most important feature of the treatment of postmenopausal (and senile) osteoporosis is the administration of anabolic steroids to stimulate bone formation."

Increased strength and vitality are manifestations of the activity of these drugs. Most clinicians have also noted reports of a sense of well-being among the subjective findings in patients receiving anabolic agents.

Since anabolic steroids are so useful, an ideal agent for the treatment of osteoporosis would be one which presented a maximum anabolic effect with a minimal androgenic effect.

Recent studies by this investigator and others[6] with a new anabolic compound, methandrostenolone,† revealed that it possessed very low androgenicity (one per cent of the androgenic potency of testosterone) and the highest anabolic activity of all presently available agents (10 times the anabolic potency of methyltestosterone).

In February, 1960, the author[7] initiated therapy with methandrostenolone in 50 patients with known osteoporosis. Clinical improvement over a period of two months was observed in 80 per cent. This was manifested by relief of pain, increased strength and vigor, and disappearance of the symptoms of fatigue and listlessness. Underweight patients gained an average of five pounds.

FOLLOW-UP REPORT

THE present report is a 2½ year follow-up of the early series of cases, with the addition of more than 150 patients for an extension of our final evaluation.

To date, the conclusions of the initial study have been corroborated by the results of our extended study.

The average daily dosage of methandrostenolone† was 5 milligrams daily for six weeks, followed by a two to four-week rest period before resuming another six-week course of therapy.

The lowest dosage was 2.5 milligrams twice a week.

Many patients requested medication during the rest period since they had felt so well during therapy.

SIDE EFFECTS

AS REPORTED previously, side effects have been minimal, especially since smaller doses have been just as effective as the earlier use of 10 milligrams daily. The most common side effect was edema, occurring in about 15 per cent of the patients. This is controlled by reduction of dosage and/or the use of hydrochlorothiazide. Female patients who had occasionally noticed a filling of the breasts, excessive moisture in the vagina and increased libido on 10 milligrams rarely experienced these effects on 5 milligrams per day. Such side reactions can usually be successfully controlled by a further reduction of the daily dosage to 2.5 milligrams.

In patitents on prolonged corticoid therapy, it has been possible to reduce the dosage of the steroid by the addition of methandrostenolone to the therapeutic regimen.

Three typical case histories illustrate the results which can be expected in osteoporotic patients on methandrostenolone:

†Tradenamed as Dianabol®, the drug was furnished through the courtesy of Dr. Daniel R. Shields, Jr., Ciba Pharmaceutical Company, Summit, New Jersey.

3. Ingle, D. J.: Ann. N. Y. Acad. Sci., 50:576 (1949).

4. Dubois, E. L.: J.A.M.A., 167:159 (July 26, 1958).

5. Reifenstein, E. C., Jr.: *Principles of Internal Medicine*, McGraw-Hill, New York, 1958, p. 664.

6. Liddle, G. W. and Burke, H. A.: Helv. Med. Acta, 27:504 (1960).

7. Tillis, H. H.: Clin. Med., 8:274 (February, 1961).

CASE REPORTS

Case 1—Postmenopausal Osteoporosis. Age 52. Onset three years after surgical menopause. Weakness and muscle pains. Treatment consisted of salicylates and estrogens without any demonstrable effects. On five milligrams Dianabol®† daily, there was a complete remission of symptoms in six weeks. She is now maintained on intermittent therapy and states that she feels well and is able to do a full day's work as a secretary.

Case 2—Corticoid-induced Osteoporosis. Female, age 44. The diagnosis of rheumatoid arthritis was made 12 years ago. For the past eight years she has been moderately controlled on steroids. Now there is x-ray evidence of osteoporosis. On intermittent therapy with Dianabol®† for 2½ years, the steroid dosage has been reduced substantially. She states that she now feels much better and stronger and is now able to do her own housework and drive her car.

Case 3—Senile Osteoporosis. A 77-year old woman had been in failing health for several years. She was hospitalized because she had lost 15 pounds. Gastro-intestinal x-ray series was negative. Laboratory studies were not revealing. Only positive finding was x-ray evidence of marked osteoporosis of the dorsal and lumbar spines. On Dianabol®† therapy she gained 25 pounds and has noted a general improvement in her health. Due to increased libido, dosage was cut to 2½ milligrams per day, on which she is maintained satisfactorily.

Interesting aspects of anabolic therapy were noted in this series. Several patients with brittle finger nails before therapy observed that their nails were stronger and did not break as easily, after they had been given methandrostenolone† for a period of several weeks.

Several female patients with scaly scalps and hair which was extremely dry with a tendency to fall out noted a concomitant increase in the oiliness and moisture of scalp and hair which became firm and silky on methandrostenolone†, similar to that of females 15 to 20 years younger. A few patients on prolonged therapy evidenced acne, a typical adolescent syndrome.

SUMMARY

1. An anabolic agent, methandrostenolone† (Dianabol®) was evaluated in a total of more than 200 patients with osteoporosis over 2½ years.

2. Clinical improvement, as manifested by relief of pain, increased strength and vigor and abatement of fatigue and listlessness, was observed in more than 80 per cent of the patients.

3. Androgenic side effects were minimal and could be controlled by reduction of dosage and/or addition of hydrochlorothiazide.

4. Because of its low androgenicity and high anabolic effect, methandrostenolone† is recommended for long-term use in the therapy of all types of osteoporosis.

5. One of the clinically important manifestations of anabolic therapy is an increased sense of well-being, strength and vitality, which is of particular value in patients with chronic diseases such as osteoporosis.

109 South Munn Avenue

The Fallacy of "Markups"

"Let me recall a series of headlines concerning fantastic markups. One such set of headlines charged a 7000 per cent markup *over the ingredient cost* of one Schering Corporation drug! . . . I can tell you that we at Baxter have a product with a far more astronomic markup *over the ingredient cost* than anything the committee released. One of our ingredients has a markup of more than half a million per cent. That ingredient is water . . . Actually, this fabulous markup gives us a sales profit of 7.1 per cent. We are not selling the ingredient. You can get that out of a faucet. We are selling injectable distilled water which will not cause a fever when introduced into the blood stream."—William B. Graham, President, Baxter Laboratories

Gustav R. Schmiege, Jr., M.D.
Haddonfield

LSD As A Therapeutic Tool*

Although lysergic acid is thought of as a hallucination-producing drug, it is also useful in the management of certain emotional illnesses.

The initials L.S.D. indicate the drug lysergic acid diethylamide. This preparation can produce a "model" psychosis somewhat similar to schizophrenia. Although this is the most widely known feature of L.S.D., it is now being used more and more to treat mental illness rather than to produce it. In 1943, Hoffman [65] accidentally discovered the hallucinogenic properties of lysergic acid diethylamide. Since then, hundreds of papers† have been written on its effects, including its effects on men, mice, Siamese fighting fish and other animals.

In general, those working with the drug use a modification of two basic approaches: (1) as a psychoadjuvant (a term coined by Abramson [70]) referring to the use of the drug to facilitate psychotherapy. Relatively small doses, usually 25 to 100 micrograms, of the drug are used in multiple sessions with the major emphasis being placed on the psychotherapy. (2) as a *psychedelic* (a term coined by Osmond [94] for the "mind manifesting" experience patients undergo under LSD). One large and overwhelming dose, 200 micrograms, 300 micrograms or higher, of the drug is used in a single session—the emphasis being placed on the experience. The therapist is present for support, but discussion is withheld until after the experience.

There is a considerable difference [50] in the reaction to small doses as compared to large doses. It is not my purpose to discuss the differences. Abramson [4,5] has published a number of verbatim sessions with small doses. Two books[5,93] written by patients present interesting descriptions. *Myself and I* [93] by Constance Newland is an especially well done book. Both Sherwood [117] and Chewelos [33] have published good descriptions of the overwhelming reaction occurring with large doses.

THE PSYCHOADJUVANT

LSD as an aid to more effective psychotherapy seems to have been inaugurated by Busch and Johnson [29] in 1950 at the St. Louis State Hospital in Missouri. There LSD was given to 29 patients. Actually, Guttman and Maclay,[60] as far back as 1936, had suggested the empirical use of a similar substance (mescaline). In 1951, Benedetti [21] reported giving 50 micrograms to chronic alcoholics to effect psychocatharsis. Savage,[113] in 1952, tried using it in daily doses as an antidepressant. Al-

*Presented at the American Psychiatric Association Annual Meeting, May 8, 1962 at Toronto, Canada. This work is from the Carrier Clinic in Belle Mead, N. J.

†A bibliographic listing of 129 references will appear in the author's reprints.

though he felt it to have no value as an antidepressant, he suggested it might be helpful in psychotherapy. Frederking,[57] in 1953, found LSD to be an aid in the psychotherapy of 25 patients refractory to analysis. Katzenelbogen and Fang,[74] in the same year, used LSD for narcosynthesis in 20 psychotics, most of whom were schizophrenic. Sloane and Doust,[120] in 1954, felt LSD to be of questionable value in the treatment of 12 depressions and seven schizophrenics. In that year Anderson and Rawnsley[18] report good results in six of 19 psychiatric patients.

Sandison[111] began a larger scale investigation at Powick Hospital in England. He published his first 36 cases in 1954. A two-year follow-up on 30 of these patients found 19 improved. Davis and Davis[44] that year used LSD on mental defectives. Although the drug had no lasting effect in itself, they felt it was useful in psychotherapy. Langner and Kemp[80] tell of 500 LSD sessions and find it "encouraging" in neurotics, schizophrenics, manic depressives and alcoholics. In 1957 and 1958, Feld, Goodman and Guido[55] reported all of 18 patients improving except those with chronic brain syndrome.

At a psychiatric day hospital, Martin[91,92] found improvement in 45 of 50 chronic neurotics. Only nine of these relapsed after two years. Sandison,[112] in a very complete presentation, tells of 94 patients receiving psychotherapy under LSD. Forty-three per cent had either completely recovered or were greatly improved. A total of 66 per cent had received some benefit.

Lewis and Sloane[86] used LSD in the psychotherapy of their patients at Maudsley Hospital in London. They felt it a definite aid in psychotherapy and made note of its helpfulness in obsessional patients. Whitelaw[127] presents in detail a case of fetishism treated successfully with LSD and psychotherapy. In 1959, Cohen and Eisner[40] reported improvement in 16 of 22 patients with six to 16 months follow-up.

Many other reports of LSD's usefulness had appeared by April, 1959 when the Macy Foundation sponsored a conference on LSD in psychotherapy. The participants at the conference had, in total, treated 1099 patients. It was there that Peck[96] reported his series of 218 patients. He felt excellent results were obtained in 64 per cent and at least good results in 86 per cent. See references 5, 6, 82, 110 and 129.

One of the most thorough presentations is that of Chandler and Hartman[32] In their series of 110 patients composed of many diagnostic categories, they found improvement in 45 per cent. Ling and Buckman[88] report 50 cases. Fifteen of these patients had recovered or greatly improved, and 76 per cent had at least moderately improved.

In addition to others who have found LSD useful in individual psychotherapy, Fontana,[56] Wijsenbeck,[128] Stevnin,[122] and Rojo,[101] tell of its facilitating communication among neurotic patients in group psychotherapy. Abramson and Sandison[2] also mentioned this. Bierer and Browne[25] and Tenenbaum[124] tell of its usefulness as an adjunct in group psychotherapy in 75 and 10 patients respectively.

THE PSYCHEDELIC EXPERIENCE

MANY investigators are using a large single dose of LSD. The suggestion that a single overwhelming experience may be beneficial was first reported by Osmond[94] in 1957. It was his feeling that this experience may be so impressive as to effect changes for years to come. Osmond cited Hubbard, who treated many gravely ill alcoholics with one large dose. All seemed to benefit to some extent. Smith[121] reports 24 alcoholics, of whom twelve were improved after a one-year follow-up. Hoffer[65] listed 60 severe alcoholics and said that 30 of them remained "dry" after a five-year follow-up. Chewelos[33] also reports of the usefulness of one dose of LSD in alcoholism.

MacLean[89] at the Hollywood Hospital in Canada, reported 100 patients who had been given one dose of LSD. Of the 61 alcoholics, 30 had considerably improved and 16 had "somewhat" improved. Of the 39 non-alcoholic patients, 22 improved greatly and another 13 had "somewhat" improved. In all, 52 per cent of these patients were greatly improved, and a total of 81 per cent had at least received some significant benefit. Ball[20] (another Canadian) has reported success in the treatment of 10 cases of sexual perversion with one dose of LSD. Sherwood[117] cites 25 patients given one dose of LSD over a five-month period. Of these, 12 had "complete resolution" of the problem for which they sought treatment. Nine were improved and four had little or no improvement.

DISCUSSION

It is impossible to get the true picture of the therapeutic value of LSD by determining what per cent of patients it has helped. It is of greater value to understand *why* investigators utilize it in their treatment. Those using LSD in multiple doses as an *adjunct* to psychotherapy feel that it is so useful because: (1) It helps the patient to remember and abreact to recent and childhood traumatic experiences. (2) It increases the transference reaction while enabling the patient to discuss it more easily. (3) It "activates the patient's unconscious" so as to bring forth fantasies and emotional phenomena which may be handled by the therapist as dreams. (4) It intensifies the patient's affectivity so that excessive intellectualization is less likely to occur. (5) It allows the patient to see his customary defenses better and sometimes allows him to alter them. Because of these effects, many practitioners feel that psychotherapy progresses at a faster rate.

There have been many reports of patients receiving meaningful insight under LSD without the aid of a therapist. Some assume that this means that LSD experience in itself may be therapeutic. Chandler [32] warns us, "The delusion that the drug in itself can produce a cure may be a temptation to the immature therapist." Yet there are many reports of patients receiving meaningful insight about themselves in an LSD experience *without* the intervention, participation or even presence of a therapist.

Those who administer lysergic acid in a single dose have as their goal, in the words of Sherwood,[117] an overwhelming reaction "in which an individual comes to experience himself in a totally new way and finds that the age-old question, 'Who am I?' does have a significant answer." Frequently, this is accompanied with a transcendental feeling of being united with the world.

Many psychiatrists feel that an individual's kinship or lack of kinship with both his human and non-human environment are important to his psychologic health. Some spectacular, and almost unbelievable, results have been achieved by using one dose of the drug.

CASE HISTORY

A 20-year old man with a six year history of antisocial "acting out" (including the overuse of alcohol and narcotics) resulting in his being expelled from various schools, jailed on one occasion and being admitted to a state hospital for three months, came to the Carrier Clinic for treatment. He received no benefit from tranquillizers or psychotherapy. He was given one overwhelming dose of LSD. A one year follow-up finds him to be a good student, captain of the football team, chairman of the student council, and no longer "acting out"—making a better than average adjustment.

Results such as this are puzzling and controversial.

Ward,[125] in a paper describing simularities between psychodrama and the LSD experience, points out that, to some investigators, treatment failures are almost a relief since this kind of spectacular success does not fit current modes of thinking. The idea that a hallucinogenic experience may produce a therapeutic response requires an alteration of many peoples' frames of reference. Naturally, there is considerable resistance toward doing so. Some have even taken the drug to demonstrate that it has no value in psychiatric exploration. Cohen [39] tells of the dysphoric responses occurring within them.

LSD administered at different dosage levels to different patients in different environments is likely to produce different reactions. Some feel the changes produced in patients after taking LSD are due to such things as the milieu, suggestion or enthusiasm of the investigator. LeFever [81] has compared the ritual developed around the use of LSD at a small, private psychiatric hospital to the puberty rituals of primitive tribes, the object of which is to help the individual in the struggle to find just who he is and what he is.

Most authorities have no trouble in accepting the thesis that a single emotional experience may affect an individual for months or years, provided the experience is traumatic. The idea that a single psychedelic experience may do likewise has been widely criticized.

Smith,[65] Hoffer[89] and MacLean[121] individually found it about 50 per cent effective in the alcoholic. Interestingly enough, the statistics of those using one dose accompanied by no psychotherapy, at least at present, bear a striking resemblance to the statistics of those using psychotherapy.

Although there is considerable disagreement as to whether one overwhelming dose will help anyone, it is my feeling that it has. The question to me is not will a single dose help anyone, but rather: whom will it help, why does it help and for how long will it help?

CRITIQUE

Valid criticism may be made of much of the literature on LSD: (1) Descriptions of the patient are frequently vague. (2) The series of patients is often small. (3) Criteria for improvement are not spelled out. (4) The follow-up is too short. (5) There is lack of control groups (admittedly a difficult research design for patients receiving psychotherapy). (6) Often the ratio of patients improving is in the range of patients receiving benefit from any psychiatric treatment.

Let us note the severity of the illness in many of the series presented. Characteristic of these is Sandison,[111] who says of his patients: "All our cases were in danger of becoming permanent mental invalids, life long neurotics, or suicides." In many instances it seems patients are getting LSD when all else fails. Yet it is stated by most that the healthiest patients respond best.

Rates of effectiveness would be higher if the subjects were not such sick groups. It is, perhaps, because LSD has been given to patients most resistant to conventional treatment that we have come to see its usefulness in three of the most difficult diagnostic categories to treat—namely, the alcoholic, the personality disorder (including the sexual deviate) and the obsessive compulsive. The one-dose technic has been 50 per cent successful with alcoholics.[30,33]

Lysergic acid has been successful in the treatment of personality disorders such as the one described above. Sandison,[108,112] Ball,[20] Peck[96] and Chandler[32] all have had some good results using LSD in the treatment of sexual deviations.

Many have found LSD particularly useful in obsessive-compulsive patients. When the series of Sandison,[112] Martin,[92] Lewis,[86] Cohn[40] and Peck[96] are combined, the total is 75 patients; recovery or great improvement occurred in 52 per cent; and moderate improvement in 33 per cent. Thus, 88 per cent have been helped. Considering that the patients were frequently "chronic" and seriously ill, these results are very encouraging. It is my feeling that the multiple dose technic has proved superior with the obsessive-compulsive patient.

How safe is LSD? Certainly the patient may experience multiple somatic complaints. This occurs especially in subjects who use somatization as a defense. Sometimes the physical symptoms may become so severe as to mimic gross physical illness such as a coronary.[30] Such violent reactions, however, are unusual. Minor neurologic disorders, mild depressions or euphoria may persist for a few days.

Suicide following LSD has been extremely rare and has occurred only in seriously disturbed individuals. It is unfair to indict LSD as the cause. Prolonged psychotic reactions have occurred in only eight out of 10,000 cases, and all of these seem to have been in decompensating schizophrenics.

Most authorities feel that compensated schizophrenics, or markedly schizoid individuals, are risky subjects because of the possibility of precipitating a psychoses. Severe physical disease is a contraindication due to the exhaustion that may occur during the experience. Some feel that LSD should not be given to patients with liver disease inasmuch as it is excreted through the liver; however, others have given the drug to individuals with severe liver disease without adverse effects. Cohen,[39] after personal communication with 44 of 62 investigators, presents a critical review of the side effects and complications of LSD

therapy based on administration to 5,000 individuals who had received LSD or mescaline on more than 25,000 occasions. He concludes that with proper precautions LSD is safe when given to a selected group. All investigators agree that *before administering LSD the therapist should have had previous personal experience with the drug, including taking it himself.* This requirement plus the fact that it has not yet been released for general psychiatric use—along with the difficulty some have to fit it into their general frame of reference, are all factors limiting its more widespread use.

CONCLUSIONS

1. Lysergic acid diethylamide has been in therapeutic use for about 12 years. It is used in two ways; one large dose may be given to elicit a "psychedelic" experience; or it may be given as an adjunct to psychotherapy in small multiple doses.

2. Although a large literature has been built up, much of it is unsatisfactory because of lack of specificity in describing patients, inadequate controls, and too few long follow-up studies.

3. The drug is often used as a last resort on very sick patients who have responded to nothing else. Therefore, good effects take on added significance because of the poor selection of subjects. Results have been especially encouraging in personality disorders, including sexual deviates and alcoholics. Good results have also been reported in obsessive-compulsive patients. Many therapists have found that LSD speeds psychotherapy in neurotics.

4. The drug has been disappointing in schizophrenics.

5. LSD has a wide safety margin and in the hands of experienced investigators does not produce hazardous side-effects.

228 Kings Highway East

Survival After Heart Attack

What is the chance of survival after a heart attack? Today, the odds are about 20 to one that the patient will survive the episode. Sigler, in the *American Journal of Cardiology* for April 1962 (9:547), comments that the likelihood of long-term survival following a heart attack has markedly improved in the past 35 years.

Up to 1930, immediate mortality rate was as high as 20 per cent. "Since 1950 the immediate average yearly mortality rate seldom surpassed five per cent, and it is usually less," he said. In 1,700 patients observed over 34 years, Sigler's findings "indicate that the prognosis of myocardial infarction is far better than it was hitherto considered to be."

In the current study he reported on 255 patients who lived 10 years or longer following acute myocardial infarction. Age at onset of the first attack in the group was between 50 and 60 years of age. About 65 per cent of the men and 89 per cent of the women still living have already lived 10 to 14 years or longer since their first attack. "A large proportion of patients have surpassed the average life expectancy," he continued. "Only two of the patients died during a second infarction; the rest are either still alive or died long after a second or even third attack."

Return to work after recovery "does not affect and may even improve the prognosis," he said. Only five per cent of the men had to give up work because of the heart disease. Retirement because of illness was most frequent in manual workers. All women patients returned to their housework.

Announcements

Blood Bank Seminar

On Saturday, June 1, there will be a seminar on blood bank operations at New Brunswick from 10 a.m. to 1:15 p.m. This is under the auspices of the New Jersey Blood Bank Commission. Speakers include Martin C. Rosenthal, M.D., of New York Mt. Sinai Hospital, T. R. Boggs, M.D. of the Pennsylvania Hospital and James L. Tullis, M.D. of the Massachusetts Protein Foundation. There will also be a motion picture on innovations in transfusion. The meeting will be in room 201 of Van Nest Hall at Rutgers. You are invited.

Foot Care Pamphlet Available

Foot Care for People with Diabetes is the title of a short, readable and authoritative pamphlet sponsored by our State Health Department. The brochure is now available gratis to you and your diabetic patients. For copies, write to Diabetes Control Program, State Department of Health, Box 1540, Trenton 25, New Jersey.

New New Jersey Pathology Diplomates

The American Board of Pathology announces the naming of four new board diplomates in our state: Dr. Vincent Galdi of New Brunswick; Dr. Lucy Rorke of Moorestown; Dr. Donald Shields of Westwood; and Dr. C. F. Varga of Plainfield.

Deaths from Mushrooms

If you know of any deaths attributable to the ingestion of mushrooms, please send a report to the National Registry of Deaths from Mycetism c/o Dr. Robert W. Buck, Massachusetts Medical Society, 22 Fenway, Boston 15.

At Your Finger Tips: A Personal 35,000 Volume Medical and Dental Library

By joining the Academy of Medicine of New Jersey, you immediately get access to the largest medical library in the state. You can borrow any book, consult any journal article, run down any bibliographic citation—by mail, by phone, by personal visit to the centrally located Academy Library in Bloomfield.

The Academy is New Jersey's unique healing arts fellowship: it is a company of medical and dental scholars. You belong there, and not on the outside looking in. For membership application, get in touch with—Academy of Medicine of New Jersey at 307 Belleville Avenue, Bloomfield, N. J. The phone number is Pilgrim 8-0544.

Medical Care to Dependents of Military Forces of NATO Countries

After July 1, 1963 the accompanying dependents of active duty military personnel, who are members of the armed forces of North Atlantic Treaty Organization countries stationed or passing through this country, will be entitled to the same care under the Medicare Program as those dependents of members of the uniformed services.

The standard Identification Form (DD Form 1173) will be furnished to those dependents and all contractual provisions and criteria as to scope of care and eligibility will be the same as for dependents of members of our uniformed services.

Medical Meeting in the South Pacific

Two medical meetings are announced this fall in the Pacific area. The Pan-Pacific Surgical Association meets in Honolulu November 5 through 13; and the same association provides its unique "mobile educational seminars" from November 14 through December 10, 1963, in New Zealand, Hong Kong, Japan, the Philippines, Thailand and Australia. Those who follow the mobile unit in the latter program will hear presentations of medical material unique to each area. For details, airmail a letter to Pan-Pacific Surgical Association, Room 236, Alexander Young Building, Honolulu 13, Hawaii.

Trustees Meetings: February 17, 1963

A regular meeting of the Board of Trustees was held on Sunday, February 17, 1963, at the Executive Offices. For the full information of the membership, detailed minutes are on file with the secretary of each component society. A summary of the significant actions follows:

HSP In-Hospital Tests . . . Suggested that HSP print (in memorandum form) a simplified statement to assist physicians in discussing Blue Cross contract limitations with their patients.

Osteopathic Licensure . . . Deferred the following recommendation until after the 1963 House of Delegates has considered and acted upon it:

> That any person fully licensed as a physician and surgeon by the State Board of Medical Examiners of New Jersey, licensed originally as holding a D.O. degree but who subsequently converted the D.O. degree to an M.D. degree through the California College of Medicine under its special program terminated on September 20, 1962, be considered to have an M.D. degree acceptable to this Society, provided that such person agrees in writing to use the M.D. degree exclusively hereafter.

AMA Delegates' Credentials . . . Accepted the resignations of Doctors Joseph P. Donnelly and Joseph R. Jehl for the second year of their current terms as AMA delegates, for the following reasons:

> In 1955 when MSNJ earned its sixth AMA Delegate, he was elected for a term of 18 months resulting in unequal division of terms—2 and 4. The AMA Bylaws stipulate that one-half the number of delegates, as near as may be, be selected each year. For the first time the AMA—on the certificate for the 1963 annual meeting—has directed our attention to the Bylaws regulation and the unequal division of New Jersey terms. To conform to the AMA Bylaws 1 delegate and 1 alternate, elected in 1962 for 2-year terms from 1/1/63 to 12/31/64, would have to resign as of 12/31/63 for the second year of their terms, 1/1/64 to 12/31/64. The offices of the delegate and alternate would then be placed before the 1963 Nominating Committee for election to 2-year terms, 1/1/64 to 12/31/65. This would equalize the division of terms—3 and 3.

Reception for Incoming President . . . Authorized financial assistance to the Essex County Medical Society in a sum not to exceed $2,000 from the exhibit receipts of the 1963 annual meeting, to further a reception for the incoming President.

Privileged Communication . . . Approved a draft of legislation—submitted by the Council on Legislation—to grant privileged communication between physicians and patients in New Jersey, together with the following recommendations in this connection:

> (1) that before this legislation is introduced, in the interest of securing maximum support, this Society—through its liaison committee with the New Jersey Bar Association—take steps to find out if the environment at the present time is any more sympathetic toward legislation of this kind; and
>
> (2) that this legislation not be introduced, unless or until there is likelihood of its being acceptable to the Bar and the Bench.

X-ray and Medical Technicians . . . Approved the report of the Council on Legislation to promote support for MSNJ's bill "to exempt certain medical and x-ray technicians from the scope of the Medical Practice Act." Also concurred in the action of the Council on Legislation in re-affirming its decision (6/21/61) *not* to introduce any other legislative measures until some positive action has been taken by the Legislature with regard to the x-ray and medical technician's bill and the school examination bill.

School Examination . . . Authorized the Executive Officer to develop support for the re-introduction of this bill if the opportunity should present itself.

Current State Legislation . . . Adopted the recommended position of the Council on Legislation concerning the following measures. All bills marked thus (*) are identical with measures of 1962—or preceding years—on which the positions were the same.

*S-1 —To provide for the formation of non-profit dental service corporations and the opera-

tion and regulation of Dental Service Plans. *No Action*

*S-4 —To authorize medical service corporations
*A-328—to include in their contracts a subrogation provision in the event a subscriber or eligible dependent receives payments for injuries resulting from the negligence or wrongdoing of a third party. *Approval*

*S-5 —To permit a medical service corporation to
*A-326—file and enforce a lien when it has made payment to a physician for services rendered and to provide for the reimbursement of the medical service corporation by the physician in the event the lien is paid. *Approval*

*S-6 —To give the Commissioner of Banking and
*A-330—Insurance authority to disapprove practices, rules and procedures of a medical service corporation where he feels they are unjust, unfair, or inequitable. *Active Opposition* . . . because, in contravention of the public interest, these measures would unwarrantedly grant the Commissioner of Banking and Insurance dictatorial powers that would invade and usurp the normal functions and discretion of the board of trustees of a medical service corporation and would thus threaten the continuance of operation of such medical service corporation in this State. (Action Bulletin sent February 7, 1963)

*S-7 —To allow medical service corporations to
*A-331—enter into agreements with other corporations to underwrite group contracts covering employees outside the State. *Approval*

*S-8 —To permit medical service corporations to
*A-329—provide group contracts covering at least 100 employees or members based upon experience rated premiums and to levy an annual supervisory fee of $20,000 on such corporations. *Approval*

*S-9 —To permit medical service corporations to
*A-306—issue master group contracts to employees and other policy holders. *Approval*

*S-10 —To permit hospital service corporations to
*A-337—provide group contracts covering at least 100 employees or members based upon experience rated premiums and to levy an annual supervisory fee of $20,000 on such corporations. *Approval.*

*S-11 —To allow hospital service corporations to
*A-333—enter into agreements with other corporations to underwrite group contracts covering employees outside the State. *Approval*

*S-12 —To permit hospital service corporations to
*A-335—issue master group contracts to employees and other policy holders. *Approval*

*S-13 —To Give the Commissioner of Banking and
*A-334—Insurance authority to disapprove practices, rules and procedures of a hospital service corporation where he feels they are unjust, unfair, or inequitable. *Disapproval* . . . in consistency with our active opposition to its companion bill affecting Medical-Surgical Plan.

*S-14 —To permit hospital service and medical
*A-327—service corporations to issue a combined contract providing for hospital and medical care. *Approval*

*S-15 —To permit hospitals to enforce liens for
*A-325—services rendered notwithstanding any portion of such charges being paid by a nonprofit hospital service corporation and to provide for reimbursement of the hospital service corporation in the event the lien is paid. *Approval*

*S-16 —To authorize hospital service corporations
*A-336—to include a subrogation provision in their contract. *Approval*

*S-17 —To amend the Charter and by-laws of the
*A-332—Hospital Service Corporation of New Jersey to provide for the appointment of 9 public trustees by the Governor with the advice and consent of the Senate, to include three from organized labor and six public. *Disapproval* . . . in support of the position of opposition of the New Jersey Hospital Association.

S-35 —To require the installation of seat safety belts on automobiles registered in the State after July 1, 1965. *Approval*

S-37 —To delete the requirement in the motor vehicle laws that a specimen for drunk driving test must be expressly consented to and substitute a ban on taking such a specimen forcibly. *Disapproval* . . . because the standard of determination of "drunken driving" used is unrealistically high, and MSNJ supports a standard of 10 per cent.

S-38 —To revise the penalties for driving while
A-46 —under the influence of alcoholic beverages. *Disapproval* . . . because the standard used is unrealistically low, and MSNJ supports a standard of 10 per cent.

S-46 —To amend the State Employees Health Benefits Act of 1961 to permit counties, municipalities, school districts and other public agencies to elect to participate in health benefit programs and provide coverage for their employees and their dependents. *Approval*

*S-57 —To provide that certain notices of hospi-
*A-136—tal and medical liens may be filed in the county clerk's office within 90 days after the first day of treatment. *Approval*

*S-62 —To define "accident" under the Work-
*A-200—men's Compensation Law to mean an un-

usual event occurring in the employment environment, other than a physical change in the employee. *Approval*

S-72 —To permit local boards of education to send children to private schools providing services for emotionally disturbed or socially maladjusted children if no suitable public school placement is available. *No Action*

S-76—To authorize county boards of freeholders to make appropriations for the treatment of mentally ill children by certain approved non-sectarian and non-profit private organizations. *No Action*

*S-77 —To prohibit the practicing of optometry in retail stores, or offices not exclusively devoted to that practice. *No Action*

*S-83 —To revise certain qualifications for persons to be admitted to examination for license to practice medicine and surgery. *Active Opposition* . . . because it would circumvent the lawful procedure for the licensing of a physician adopted by New Jersey as a means of protecting the public against unqualified practitioners. Thus it is contrary to the public interest and unfair to all physicians legitimately and properly licensed by the State of New Jersey through the Board of Medical Examiners.

*S-85 —To increase allowances for reimbursement
*A-364—from federal and state funds for community mental health projects. *No Action*

*S-103—To provide that services performed by a duly registered bioanalytical laboratory are within the scope of medical service plans. *No Action*

S-118—To authorize hospital service plan coverage of health care services by voluntary non-profit visiting nurse organizations elsewhere than in a hospital. *Approval*

S-124—To authorize changes for diagnostic services and treatment at county mental centers or institutions. *Approval*

S-135—To broaden the protection afforded employers in second accident prior disability cases under the Workmen's Compensation Act. *Approval*

*S-138—To exempt certain medical and x-ray technicians from the scope of the Medical Practice Act. *Active Support* (sponsored by MSNJ)

*S-143—To define the practice of chiropractic as "a system of adjusting the articulations of the spinal column and related tissue by manipulation thereof." *Active Opposition* . . . because it is an unwarranted extension of the scope of the practice of chiropractic; and would give responsibility and privilege in areas for which chiropractors are not competent.

*A-36 —To make the requirement that containers shall be marked with the date of pasteurization, applicable to cream. *Disapproval* . . . in conformity with the opinion of the U.S. Department of Health, Education and Welfare that "the disadvantages are more significant than any advantages that may now be claimed for the dating of pasteurized milk" and in support of the contention of the Department of Health that the bill is not warranted or necessary.

*A-38 —To provide for the registration and examination of dental laboratory operators and their assistants by the State Board of Registration and Examination in Dentistry. *Disapproval* . . . in support of the position of the New Jersey State Dental Society which contends that the bill is loosely drawn.

A-39 —To authorize the temporary commitment of drug addicts to the New Jersey Neuropsychiatric Institute. *No Action*

A-40 —To provide that patients may be admitted to the New Jersey Neuropsychiatric Institute by order of a court on conviction of a crime or before being charged with a criminal offense. *No Action*

*A-62 —To exempt licensed medical practitioners from civil action arising out of emergency care at the scene of an accident. *Approval*

*A-79 —To permit an injured employee to select the physician he wishes to treat him under the Workmen's Compensation Act. *Approval*

*A-111—To revise generally the laws dealing with mental health and mentally retarded persons—an Act to be known as the "Mental Health Act of 1963." *Approval*

*A-112—To establish the power of the State Board of Institutions and Agencies to classify the functions and establish specialized facilities, and services of various institutions. *Approval*

*A-113—To make technical amendments in various statutes dealing with mental incompetents and their guardians. *Approval*

*A-144—To limit the time for bringing actions at law by parents or guardians on behalf of minors under the age of 21 derived by reason of an injury to such minor. *Approval*

A-164—To permit non-profit hospital corporations to receive wage assignments in return for care or treatment to patients. *No Action*

A-190—To increase the penalties for violation of the narcotics laws. *No action*

*A-193—To provide that data in possession of the State Department of Health, pertaining to the health of any named person, procured in connection with research studies, approved by the Public Health Council, for the purpose of reducing the morbidity or mortality from any cause or condition of health shall be kept in confidence by the Department except to persons participating in research study or in such impersonal form that the individual concerned cannot be identified. *Approval*

A-196—To permit the renewal of certain limited partnership associations and establish a procedure for same. *No Action*

*A-199—To limit the subrogation rights of insurance companies, or medical or hospital service corporations with respect to third party recoveries for hospital or medical services. *Disapproval* . . . in consistency with our approval of S-4 and A328.

A-243—To grant certain exemptions from specific requirements for physicians' licenses to M.D.'s on the staff of a state or county agency. *Approval*

*A-244—To establish the procedure for the Banking and Insurance Commissioner to disapprove rates of medical service corporations and for court review thereof. *Active Opposition* . . . because it would empower the Commissioner of Banking and Insurance to fix fees to be paid by MSP to participating physicians and would, therefore, constitute an unwarranted and unjustifiable denial of the fundamental right of the physician to set his own fee for professional services rendered, thus threatening the operation of the Plan, in disregard of the best interests of the approximately two million people of New Jersey who are its subscribers.

A-287—To revise the definitions and regulations concerning boarding homes for the sheltered care of adults. *Action Deferred* . . . pending study and report by the Special Committee on the Chronically Ill and the Aging, to which the council referred the bill.

A-288—To include "rest homes" under the regulations affecting nursing homes and private hospitals and make certain other changes in that law. *Action Deferred* . . . pending study and report by the Special Committee on the Chronically Ill and Aging, to which the council referred the bill.

In conjunction with A-287 and A-288, the council considered a communication from the Licensed Nursing Homes Association requesting comments on these bills.

A-313—To grant to married minors and unmarried pregnant women who are minors the legal right to consent to the performance of hospital, medical, or surgical care. *Approval*

*A-316—To increase the penalties of certain narcotic violations and to forbid suspension of sentences. *No Action*

*A-317—To provide a prison term of not less than 20 years for hiring or use of any child under 18 years of age in illegal sales or transactions of certain narcotic drugs. *No Action*

*A-318—To provide that no person other than a pharmacist, shall sell any preparation or mixture or compound of drugs containing codeine or any barbiturate to any person under the age of 21, except upon a written prescription of a physician, dentist, or veterinarian. *Disapproval* . . . until recommendations for broadening the prohibition are included.

*A-319—To make possession by unauthorized persons of certain barbiturates, hypnotic and tranquilizing drugs, without a prescription, a disorderly persons offense. *Approval*

*A-320—To forbid the suspension of any sentences for the illegal manufacture or sale of narcotic drugs. *No action*

A-338—To extend the time for filing petitions under the Workmen's Compensation Act in cases of exposure to ionizing radiation. *Approval*

A-340—To authorize the joint underwriting of health insurance for persons 65 and over and to provide the premiums received for such policies shall not be included in determining certain taxes on insurance companies. *No Action*

A-341—To transfer certain approval powers over hospital service corporations from the Commissioner of Institutions and Agencies to the Commissioner of Banking and Insurance. *No Action*

*A-361—To prohibit the discharge of sewage into State waters from boats except through certain prescribed marine toilets. *Approval*

A-364—To increase allowances for reimbursement from Federal and State funds for community mental health projects. *No Action*

A-378—To forbid hypnotizing as a form of enterment. *Approval*

A-440—To amend the Uniform Narcotic Drug Law with respect to Narcotic Prescription Forms. *Disapproval* . . . because it is unnecessary and unrealistic, and places a burden on the general public to protect itself against forgers and counterfeiters.

State Board of Optometrists vs. Reiss . . . Rejected the request of the Special Committee on the Conservation of Vision that MSNJ "join this action to protect not only ophthalmologists, but the basic principle that medicine has the traditional right to render or supply such services that, in its medical judgment, are required for the proper practice of medicine." for the following reasons:

(1) The obvious weakness of the Reiss case manifests the vulnerability of physicians in utilizing the services of opticians, which MSNJ has sought to vitiate by amendment to the Medical Practice Act; and

(2) Emphasis by MSNJ should be legislative rather than judicial. Legislative inclusion on the list of those exempted from the prohibitory provisions of the Medical Practice Act of "medical and x-ray technicians" when operating under the specific direction of a licensed physician would solve the problem.

Home Care Program . . . Approved the Home Care Program, as outlined by the Special Committee on the Chronically Ill and the Aging, and approved by the Council on Public Health. It follows:

HOME CARE PROGRAM

of

The Medical Society of New Jersey

Objectives: To provide certain extension services to patients in the home which would normally be provided in the hospital.

The Home Care Program should have the approval of the local county medical societies or their definitive committees.

Referrals: All referral of patients to the Home Care Program must initiate from the patient's own physician.

Personnel: The personnel of the Home Care Program will consist of a team under the direction and coordination of a medical doctor. The team will include the patient's own physician, the coordinating physician (who should be a doctor of medicine), and other related personnel (such as a social worker, physical therapist, registered nurse, etc.).

Evaluating the need of the patient is a job for the entire team.

Cases to be Covered: There is to be flexibility in the selection of eligible participants in the Home Care Program—not merely chronic illnesses to be considered, but acute illnesses as well.

The responsibility for developing the procedures to implement and continue the Home Care Program is vested entirely in the coordinating team, and should provide the following:

1. Coordination by coordinating physician.
2. Services of the home care team, such as the patient's physician, the coordinating physician, and other related personnel.
3. Homemaker services, when necessary.
4. Maintenance of medical records.
5. The program should make available the essential supplies and equipment necessary for the proper care of the patient.
6. Laboratory services.
7. Radiology services.
8. Transportation from the home to the hospital and return should be provided for any special services.

1963 Seminar on Veterinary Medicine . . . Approved the recommendation of the Council on Public Health that MSNJ co-sponsor this seminar.

Materials to Press . . . Authorized the distribution of materials to be considered by the House of Delegates, and as submitted to the House in its first session, to accredited representatives of the press after the opening of the House.

Intern Approval Program . . . Authorized the preparation of a suitable resolution, calling upon the AMA House of Delegates to rescind its action in this matter, for introduction in the New Jersey House of Delegates and subsequent distribution to the other 49 state delegations . . . Received a resolution from Somerset County Medical Society opposing this program. At the request of the Somerset County Medical Society, it was reported that all New Jersey AMA Delegates voted in opposition to the report of the Council on Medical Education, which was adopted by the AMA House of Delegates at the meeting in Los Angeles.

Signatures on Checks . . . Designated the Chairman of the Committee on Finance and Budget as Acting Treasurer, to serve when the Treasurer is protractedly unavailable.

County Reports in THE JOURNAL . . . Referred to the Publication Committee a letter from the Monmouth County Medical Society disapproving the discontinuance of County Society Reports in THE JOURNAL.

March 17, 1963

A regular meeting of the Board of Trustees was held on Sunday, March 17, 1963, at the Executive Offices. For the full information of the membership, detailed minutes are on file with the secretary of each component society. A summary of the significant actions follows:

Radiation Protection Commission . . . Appointed Dr. Louis J. Levinson of Newark to act as MSNJ's consultant to the Commission, in compliance with the Commission's request for closer rapport with MSNJ.

Compensation of Interns and Residents . . . Directed that all New Jersey AMA Delegates receive copies of a communication from the Hackensack Hospital Association, offering "unqualified support to the New Jersey AMA delegation and others opposed to the means of compensation for interns and residents recommended by the AMA Council on Medical Education and Hospitals and the AMA Council on Medical Service."

. . . Directed that a letter be sent to the appropriate councils and officers of the AMA and to the heads of all state delegations to the AMA, protesting the action of the AMA's Council on Medical Education and Hospitals in soliciting support of its report from hospital administrators and hospital governing boards before the AMA House of Delegates has formally received and acted upon that report.

AMA Medical-Legal Symposium . . . Received Legal Counsel's report of his attendance as MSNJ's official representative at the recent Miami symposium.

Professional Service Corporation Act . . . Accepted Legal Counsel's caution to members of MSNJ "against hasty organization under the new Law (Chapter 233 of 1962) in an effort to gain tax advantage without very careful consideration of other factors involved which might more than offset any possible tax advantage."

AMA Legislative Conference . . . Authorized the attendance of Doctors C. Byron Blaisdell, A. Guy Campo, and John S. Madara to the AMA conference, with expenses to be paid by the AMA.

Physicians Placement Service . . . Adopted the recommendation of the committee that members of MSNJ who are seeking associates be permitted to list this information in the classified section of THE JOURNAL, free of charge, for a maximum of three months, under uniform terms established by the Physicians Placement Committee in consultation with the Publication Committee.

Discontinued the Physicians Placement Service and its sponsoring committee, because the end results did not justify the expense to the Society.

Medical Self-Help Program . . . Approved the recommendation of the Special Committee on Disaster Medical Care that a letter—similar to the one already sent to public school authorities—be sent to the Diocesan superintendents of the parochial schools in New Jersey, urging that the Medical Self-Help Training Program be integrated in the health education of all their secondary schools.

JOURNAL Cover . . . Approved the recommendation of the Publication Committee that THE JOURNAL have a new cover, printed in one color ink.

Dues-Exempt Members . . . Approved the recommendation of the Publication Committee that dues-exempt members receive THE JOURNAL as a benefit of membership, as they do all other periodical literature, for the fiscal year 1963-64.

Bad Debts . . . Approved the recommendation of the Publication Committee that a total of $348.10 in delinquent advertising, covering a period of April 1959 through April 1962, be written off as bad debts, with the stipulation that the local publisher's representative rebate the commission already paid him.

Executive Director . . . Changed the title of "Executive Officer" to that of "Executive Director."

Employee Benefits . . . Authorized the Blue Cross Expanded Policy and Rider J to be provided to all employees at the annual cost of $438.12.

Radiation Therapy Under Blue Cross . . . Directed that the Radiological Society of New Jersey receive a copy of the survey results, conducted by Hospital Service Plan of New Jersey, regarding billing arrangements for radiology and pathology.

. . . Noted that this survey revealed that the majority of New Jersey hospitals do not permit physicians to charge privately-referred patients as their own private patients.

Nominations for MSP Board . . . Approved (by a vote of 9 to 4) the nominations on the Board of Trustees of MSP for three-year terms 1963-66):

Name	Type of Practice and Component Society
Charles W. Barkhorn, M.D.	Otolaryngology Essex
Irving P. Borsher, M.D.	Internal Medicine Essex
F. Clyde Bowers, M.D.	Internal Medicine Morris
Robert G. Boyd	
Charles L. Cunniff, M.D.	Internal Medicine Hudson
Andrew P. Dedick, Jr., M.D.	Radiology Monmouth
Gustave E. Wiedenmayer	
*Charles O. Tyler, M.D.	Pediatrics Camden

*To fill the unexpired term (1963-65) of Mr. David L. Yunich, resigned.

MSA Board of Governors . . . Approved the nominations for membership on the Board of Governors of MSA for 1963-64:

Irving P. Borsher, M.D.
Harry N. Comando, M.D.
Arthur W. Lunn
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.

Medical Student Loan Fund . . . Received and noted an acknowledgment from Governor Hughes of the Board's contribution to the Medical Student Loan Fund in memory of the late Commissioner Tramburg.

Invalidated M.D. Licenses . . . Received the action of the State Board of Medical Examiners in agreeing to notify the State Society of which a licensee is a member, when his license is revoked or suspended or restored.

Seton Hall Chapter of SAMA . . . Voted to contribute $400 to the Seton Hall Chapter of SAMA for the expenses of its delegates to the national convention in Chicago, March 1-4, 1963.

SAMA Membership . . . Agreed not to become a sustaining member of the national association, in view of MSNJ's supporting the local chapter.

Bergen County Resolutions . . . Received two resolutions from the Bergen County Society for submission to the 1963 House of Delegates: (1) disapproval of change in requirements for intern approval programs, and (2) opposition to Union Family Health Groups.

Bound JOURNALS . . . Accepted the offer of Princeton University to donate bound volumes of THE JOURNAL of MSNJ from 1905 through 1935.

Hospital and Nursing Home Plan . . . Received and noted Resolution #23—referred by the 1962 House to the Board for study and action—"on the basis that so many of its aspects involve Federal governmental agencies which are impossible for the Board to implement."

Scientific Exhibit . . . Agreed to accept a scientific exhibit at the annual meeting, submitted by the State Department of Health, with the proviso that: (1) a physician be in attendance at all times during exhibit hours, and (2) blood sampling be limited to physicians only.

Drug Industry Contributions

"All American industry has contributed, but I must give a special vote of thanks to the pharmaceutical industry, which has contributed in excess of $1 million in cash and drugs to our effort. I have no idea how many other foundations like our own are able to carry on their work because of this great industry, but because this industry has a heart, this award belongs as much to them as it does to me." —William B. Walsh, M.D., founder of Project HOPE.

Obituaries • • •

DR. MAURICE AXILROD

February 20, 1963 marked the close of a long medical career in South Jersey with the death on that day of Dr. Maurice Axilrod, an Atlantic City urologist. Born in Atlantic City in 1893, Dr. Axilrod received his M.D. at the University of Pennsylvania in 1916. He was active in the affairs of the Atlantic County Medical Society and was chief of the venereal disease clinic at the Atlantic City Hospital.

DR. JOHN RAYMOND AYERS

A promising psychiatric career was prematurely terminated on March 25, 1963 with the death that day of Dr. John R. Ayers. Born in Boston in 1917, he received his M.D. at Johns Hopkins in 1942. After an internship in his native city, he entered the Air Force, becoming chief of psychiatry at an Air Force Hospital. In 1946 he entered the University of Michigan Hospital as a psychiatric resident. He then became chief of the reception service at the Farnhurst (Delaware) State Hospital. In 1949 he accepted appointment as director of the clinic at the Marlboro (New Jersey) State Hospital and in 1952 left to enter private practice of his specialty in Red Bank. Dr. Ayers was active in the Monmouth County Medical Society.

DR. DAVID BORNSTEIN

A malignancy took the life of Dr. David Bornstein, who died after a long illness on February 28, 1963. Born in Europe in 1900, he came to this country in infancy. He received both his baccalaureate and medical degrees at the University of Indiana, the latter in 1934. He was active in civic and religious affairs in the Paterson area and was on the medical staff at Barnert Memorial Hospital there.

DR. FRANCIS X. BROPHY

One of Hudson County's veteran ophthalmologists died on February 9, 1963, with the passing on that day of Dr. Francis X. Brophy. Born in New York City in 1897, Dr. Brophy earned his M.D. at Fordham in 1921. Following his internship, he had several years of general practice in New York City, and then crossed the Hudson. Becoming increasingly interested in ophthalmology, he did graduate work in that specialty and served on the staff of the Jesery City Medical Center. From 1931 to 1934 he was chief of ophthalmology in the outpatient department of that hospital. Dr. Brophy was a past-president of the Hudson County Medical Society.

DR. CHARLES G. CRANE

A unique half-century medical career came to an end on March 2, 1963, with the death of Dr. Charles G. Crane. Dr. Crane was born in Newark in 1883. In 1912 he won his M.D. at Columbia University's College of Physicians and Surgeons. He was always a family doctor. Dr. Crane was, for some years, president of the medical staff at St. Michael's Hospital. He was also affiliated with Newark Presbyterian and the Crippled Childrens' Hospitals. For three decades he was a medical consultant for the Bell Telephone Company. Dr. Crane was a beloved figure in Newark's little Chinatown and more than half of the Chinese-American babies born in Newark were delivered by Dr. Crane. A year ago he was one of the laureates of our Society's Golden Merit Award.

DR. PAUL HALEY

At the untimely age of 54, Dr. Paul Haley died at his home on March 25, 1963. Born in Irvington, he had lived for half a century in Newark. He earned his M.D. at Georgetown in the class of 1932. Dr. Haley interned at the Newark City Hospital. A general surgeon, Dr. Haley was affiliated with St. James, Babies' and Presbyterian Hospitals. He was active in the Knights of Columbus and in the Physicians' Club of Newark.

DR. M. LEONARD KIMMEL

One of the country's leading authorities on natural childbirth, Dr. M. Leonard Kimmel, died of a heart attack on March 15, 1963. He was born in New York City in 1906 and received his M.D. in 1931 at Dalhousie in Canada. Active in the Hud-

son County Medical Society, Dr. Kimmel considered himself a general practitioner. He was, however, adjunct surgeon at the Jersey City Medical Center, and by reason of his expertise in natural childbirth, he was well known in both obstetrical and psychosomatic circles. He was a consultant to New York's Maternity Association.

DR. ALEXANDER PALLADINO

Alexander Palladino, M.D., of Bridgeton, New Jersey, who practiced medicine there since 1945, died suddenly on December 31, 1962 at the Bridgeton Hospital. A native of Italy, Dr. Palladino was a graduate of the University of Naples and served during World War II as a major with the Italian Army. He became a U.S. citizen and moved from Orange to Bridgeton in 1945 and began his practice there. He was a member of the Cumberland County Medical Society. Dr. Palladino was a general practitioner—a family doctor in the traditional sense.

DR. JOHN V. SHULL

Death came on March 25, 1963 to Dr. John Virgil Shull. Born in Pennsylvania in 1887, he earned his M.D. at the University of Maryland in 1910. He practiced in New York for two years and then moved to the Raritan Bay area in New Jersey. Dr. Shull was, for many years, health officer to the Port of Perth Amboy. He was physician to the Elks Crippled Children Commission and school physician for the town of Perth Amboy. Dr. Shull was a general practitioner with special interest in anesthesiology and he was one of the anesthesiologists at the Perth Amboy General Hospital.

DR. HUGH H. TYNDALL

While on a Florida vacation, Dr. Hugh H. Tyndall died suddenly on March 10, 1963. Born in 1887, Dr. Tyndall won his M.D. in 1912 at the University of Vermont. He interned in Staten Island and then crossed over to New Jersey where he opened an office in Weehawken. Dr. Tyndall soon became prominent in many civic affairs. He was a director of the Hudson County National Bank and an officer in the Knights of Columbus. He had a tour of duty as president of the North Hudson Physicians' Society. During his half-century of practice, he limited his work largely to surgery. Dr. Tyndall served a term on our State Board of Medical Examiners. He held staff positions, including many appointments as chief of surgery or attending surgeon, at many hospitals, including St. Mary's in Hoboken, Christ Hospital in Jersey City and Holy Name in Teaneck.

DR. W. E. WAKELEY

After a half-century of medical practice, Dr. William Easton Wakeley died at his home in Orange on March 16, 1963. Born in New York, he was graduated in 1915 from Columbia University's College of Physicians and Surgeons. A general practitioner for many decades, Dr. Wakeley was a pioneer in phthisiology and served for 25 years as president of the Anti-Tuberculosis League of the Oranges. He was consultant to the Essex County Sanatorium in Verona and at the Orange Memorial Hospital. He was a Fellow of the American College of Chest Physicians.

DR. WILLIAM CARLOS WILLIAMS

In some respects, William Carlos Williams was one of the best known physicians in New Jersey. He was one of the few with a truly international reputation—in his case, world-wide acclaim as a poet. He was born in Rutherford in 1883 and he died there in his sleep on March 4, 1963. He received his M.D. at the University of Pennsylvania in 1906. He was a pioneer in pediatrics, one of the first men in the United States to make it a specialty. He did graduate work in pediatrics in Germany and in Switzerland in 1907 and 1908 when practically no such teaching was available here.

Dr. Williams first became known as a poet in 1909 when a slim volume of his won a national prize. Since then, blue ribbons in poetry and literature came his way in a regular procession. The list of awards and prizes and famous poems and odes is a long one. So is the list of honorary degrees and fellowships. But to the people of Bergen County, he was known chiefly as a pediatrician—and a good one.

Letters to The Journal • • •

To the Editor:

On February 20, 1963, a group of us were most fortunate in hearing a Symposium on "Epilepsy and the Law" under the able chairmanship of Dr. Ira S. Ross. The occasion arose out of a malpractice action in which several physicians were sued as a result of injuries and death in a motor vehicle operated by a patient with epilepsy. The patient obtained his license fraudulently by concealing his illness against the repeated admonitions of the physicians. The doctors had failed to comply with the law which requires that epilepsy be reported to the Health Department. In a normal procedure, this information is given to the Motor Vehicle Bureau which may hold a hearing with reference to revocation of the license. The laws in Ohio and Wisconsin do not require that a physician report the disease.

Since this case, there has been an upsurge in the reporting of epilepsy. This has been a problem to the Motor Vehicle Bureau because it is now up to them to process these reports. It is difficult to determine what is epilepsy, since there is no legal definition. Is it one seizure, many seizures and what other than a grand mal convulsion constitutes a seizure? Another problem that arises is this. Will the need for reporting keep the epileptic from his physician because he is afraid he will be reported? A question was also raised as to the liability of a physician to suit if he reported someone who then lost his license and it was subsequently shown that he actually did not have epilepsy.

Epilepsy is one of the few reportable diseases *not* in the contagious disease category and for which there appears to be no sociologic need. As a human being and as a physician, I do not want anyone driving a car who is a menace to himself or to other people and will do whatever is necessary to report dangerous drivers, be they epileptic or syncopal, homicidal or suicidal with their cars. I will also report persons who, I consider, to pose a threat to the lives of themselves or anyone else in what is my best-judged, best considered procedure. I will, however, not deprive a patient of mine, who poses no threat or a negligible threat to himself or others, the right to drive an automobile and since reporting him to the Department of Health may involve the loss of his license, I am willing to be a criminal or a civil martyr.

I hope that I have many colleagues who feel as I do that we can't play every situation perfectly safe for ourselves. We must think in less selfish terms. This is one of the reasons for carrying malpractice insurance and a malpractice award against us is not always an indictment of the doctor who lost the case nor is it necessarily a sign of greed on the part of the successful plaintiff.

Shall we play it safe and forbid every patient for whom we prescribe a tranquillizing drug to drive his car, have it in writing, and have the patient acknowledge this by signing his name before a witness so that we shall not be sued in the event he has an accident and blames it on the medicine he is taking and subsequently the doctor?

R. D. ROECKER, M.D.

Radiation Protection Surveys

X-ray protection surveys are needed to be sure that there are no undue radiologic hazards to the people of New Jersey. These surveys are also useful in providing legal protection for the employer against unjustified damage suits alleging overexposure to radiation by either patients, employees, or nearby residents. They will also serve to indicate whether personnel monitoring devices should be worn as required under the Radiation Protection Code.

Here are some excerpts from our radiologic protection code:

Section 8.1.1. Controlled areas shall be surveyed by or under the direction of a qualified individual using suitable instruments and methods for measuring radiation, to determine the dose rates to which any individual may be exposed. These measurements shall take into consideration the time the radiation is being produced, the work week and the fraction of the week that any individual may be exposed. Subsequent surveys shall be conducted to assure that the dose rates have not substantially increased and that they remain in compliance with the magnitudes stipulated in this Code.

Section 8.2. Surveys shall be made outside controlled areas at sufficient intervals and locations as may be necessary to insure compliance.

Section 8.3. A written statement signed by a qualified individual and including his calculations and analysis of the dose rates in the vicinity of a radiation source may be acceptable in place of the survey required in Section 8.1.1 and Section 8.2 above.

Section 9.2.1 Records shall be maintained showing the results of surveys.

Section 9.2.2. The records of each survey shall be retained for at least ten years.

For a roster of persons qualified to make these surveys, and for further details and a list of minimum requirements, write to Radiological Health Program, State Health Department, Box 1540, Trenton 25, New Jersey.

Book Reviews • • •

Surgical Anatomy of the Colon, Rectum, and Anal Canal. By Harry E. Bacon, M.D. and Mayo Recio, M.D. Philadelphia, 1962, Lippincott. Pp. 152. ($12)

Doctors Bacon and Recio have covered the field of surgical anatomy of the colon, rectum, and anal canal in 152 pages and 69 illustrations. The material is current and such procedures as rectal biopsy for Hirschsprung's disease are mentioned. By nature of their vast surgical experience, the authors have given this text a clinical orientation. The section on the anatomy of the colon is especially informative to the operating surgeon. Correlation of embryology and surgical anatomy is clearly pointed out. Among the experts, there will always be, I suspect, considerable discussion about some of the areas, most notably the endopelvic fascia.

The neat, almost schematic illustrations are a unique feature of this book. The choice of a Japanese illustrator adds to the international appeal of this text. The material on physiology at the conclusion is welcomed; but the lack of recent bibliographic contributions deserves note. The bibliography, overall, covers major contributions, both in the English and foreign literature and will serve as an important source for workers in the field. The publishes have shown reader consideration in the size of this book, and again in the two-column pages.

We are fortunate to have this pleasantly readable addition to surgical anatomy. Like the authors' previous writings, I am sure that it will go through many editions.

GEORGE LAWRENCE BECKER, M.D.

Lower Digestive Tract. Part II of Volume 3, Digestive System, The Ciba Collection of Medical Illustrations. Frank H. Netter, M.D. New York, 1962, Ciba Pharmaceutical Company. Pp. 243. ($15.)

This is the second of three volumes. The first concerned the esophagus and stomach; and the third covered the liver. The drawings are excellent; the colors are sharp and clear. Gross anatomy and, in many instances, microscopic photos and roentgen films are presented. Schematic drawings often graphically illustrate details of patho- physiology. Although it is entitled *Collection of Medical Illustrations* there is a considerable accompanying text. The latter, however, suffers from occasional inaccuracies, inadequacies and over-simplified definitions. For example, (p. 99) the definition of diarrhea is too literal; (p. 50) the function of the gastrointestinal tract is given in too elementary a fashion; the statement that ileo-proctostomy for ulcerative colitis "is gaining rapid acceptance as the operation of choice in the surgical treatment" is hardly accurate. This operation has never been accepted by experienced surgeons and is being discarded by those who have employed it.

Because of rapid advances in ultramicroscopy, concepts change rapidly. Pinocytosis is considered to be the method by which lipids are absorbed from the surface of the small intestine into the epithelial cell. Present investigators seriously question this mode of action. On the other hand, the descriptions of small bowel function and aganglionic megacolon are excellent. A minor defect refers the bibliography to the plate number rather than to the text.

This book is a valuable addition to the library of every physician. A graphic illustration of disease that can be shown the patient is one of its useful purposes.

ABRAHAM I. FRIEDMAN, M.D.

Basic Anxiety. William J. Garre, M.D. New York, 1962, The Philosophical Library. Pp. 123. ($5.00)

A new-born infant can sense rejection or resentment in a parent. From this, writes Dr. Garre, "develops basic anxiety. It is the task of this book to show the extent to which this basic anxiety is the key to personality adjustment, the focal point of our difficulties in orientation, the cause of our diseases and maladjustments and, in fact, the central point in the adaptation of human to life." Juvenile delinquency is explained in terms of a boy's rebellion against an unsatisfactory or rejecting father. Psychotherapy is seen as a way of generating sympathy as reassurance against the rejecting mother person. The theme and the text are provocative of thought as well as of disagreement. The lack of an index seriously reduces the book's usefulness. This slim volume with wide margins and large type seems overpriced at five dollars.

Any paragraph selected at random will illustrate the slow pace of the writing and its didactic quality. For example: "Psychiatry itself is potentially the realistic answer to human disturbances; however, the inadequacy of the psychiatrist assures persistency of human shortcomings, inasmuch as the very patients who have the highest degree of developmental potential, namely those who generally are classified under the neuroses, are unable to obtain the full measure of their requirements in intellectual understanding and the full investment of their need in respect to the emotional empathy made available to them."

See what I mean?

HENRY A. DAVIDSON, M.D.

Thoracic and Cardiovascular Surgery with Related Pathology. Gustaf E. Lindskog, M.D.; Averill A. Liebow, M.D.; William W. L. Glenn, M.D. New York, 1962, Appleton-Century-Crofts. Pp. 1024. Illustrated.

To appreciate the rapidity with which the field of thoracic and cardiovascular surgery is changing, compare the present edition of *Thoracic and Cardiovascular Surgery* with the one published in 1953. The excellent effects of the surgical treatment of pulmonary tuberculosis, the outstanding results in the surgical treatment of aneurysms by excision and graft, the rapidly declining mortality and morbidity of the open heart surgery, the use of artificial valves and pacemakers are just a few examples of the accelerated rate in the evolution of thoracic surgery. Writing a static textbook on such a highly dynamic and changing subject is no small feat; and Drs. Lindskog, Liebow and Glenn deserve great credit in taking on such a difficult task with such great success. What makes this book unique is the detailed historical evolution of surgical procedures, thus helping the reader to understand the present refined methods. I highly recommend this to those interested in this field.

ADRIAN M. SABETY, M.D.

Illustrated Manual of Neurologic Diagnosis. R. Douglas Collins, M.D. Philadelphia, 1962, Lippincott. Pp. 177 with 150 illustrations. ($12.00)

Neurology is seen as a kind of geometry in this profusely illustrated, neatly schematized text on diagnosis. Neurologic examination technics are shown by line drawings (flashlight aimed at eyes, *e.g.*, for pupillary response). Each major neurologic disease is presented by a concise case report (unnecessarily weighted down by giving the patient's race) and then an illustration of the brain and cord with the involved area stippled in. An appendix tabulates the major areas (cerebellar, medical lemniscus and so on) and the kinds of examination needed to bring out deficits in that area. Another appendix lists characteristic evidences of involvement of major tracts (thus, analgesia suggests involvement of peripheral nerve sensory root or ventral commissure). A third tabulation groups signs of lesions above and below the foramen magnum.

Reference diagrams of the brain and cord are found in the end-plates. The illustrations are beautifully clear. Unhappily the author's compulsion to see everything in tabulation or diagram results in a confusing picture, since textual description is sketchy and the reader is left with a brusque, nakedly skeletonized concept of neurologic disease. But the book does provide a ready reference *vade mecum* for neurologic diagnosis.

ABRAHAM LEFF, M.D.

Dr. Mary Walker, the Little Lady in Pants. Charles McCool Snyder. New York, 1962, Vantage Press, Inc. Pp. 166. Illustrations. ($3.95)

What a wacky little woman! It's easy to read the life story of Dr. Walker and simply laugh her off as an eccentric publicity hunter; but you find, in the end, you can't.

Especially as a modern hen medic, no matter how hard one tries to chuckle at all her escapades, there is a nibbling at the conscience. We've all got to hand it to her—darn it—we *owe* it to her. If it hadn't been for her type we present-day females wouldn't have had a chance.

A studious father who felt his kids should have a profession apparently set her off to a career of medicine. She sweated out the expected problem of admission and graduation from a (questionable) medical school. The Civil War, however, really gave her the big chance to fight for a cause. She forced her services on the Union contingent whether they wanted them or not. And captured, she even treated civilians in the South. (Awarded a Congressional Medal of Honor after much demanding, it was revoked in 1917).

From then on, she simply searched out causes to espouse. An unhappy, short-lived marriage with a classmate certainly influenced many of her ironclad opinions. (She wore pants to her wedding.) She progressed from bloomer girl to simply men's clothes—all as a defiance to limitation of women. She toured England and part of the continent, and was certainly in the company of royalty more than once. (Her stories magnified as she aged.) Her speeches ranged from her Civil War experiences to temperance.

Her great cause was women's suffrage. She covered the East and Middle West to speak for women's rights. The crowds came to see the pants if not to hear the speech.

Admiration is constantly aroused for her, even though many of the stories are of doubtful authenticity. However, she never fails to spoil her success. She constantly breaks up with her cohorts —the men in the army complain about her, her suffragette friends go off in a huff, even her individual friends in her old age leave her.

Nevertheless, weird as she may seem, the book cannot be read without developing a lot of respect for Dr. Walker. We are indebted to her and her kind for a lot, and her feeling for medicine is inspiring.

Mr. Snyder has collected many documents to recount his story, and most happily was able to speak with people who knew the heroine personally.

PHOEBE HUDSON, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

MAY, 1963 • VOL. XXXVI, No 5

FATAL CHRONIC BRONCHITIS

In the United States chronic bronchitis is usually thought to precede emphysema in fatal cases, but a correlation between clinical observation and morphological findings in four patients showed death can be caused by chronic bronchitis.

Chronic bronchitis has been recognized as a pathologic and clinical entity in Great Britain and is widely regarded there as the principal cause of diffuse pulmonary emphysema. In the United States, chronic bronchitis has until recently been regarded as a "wastebasket diagnosis," made when the cause of a chronic cough was not clear. Furthermore, physicians in the United States commonly assume that when British patients die of chronic bronchitis it is the associated emphysema or loss of alveolar walls which kills them, that is, that chronic bronchitis per se is a nonfatal disease.

In the present study, for three years the lungs of persons who died from various causes in two hospitals were examined to establish the morphologic basis for the clinical and physiologic signs and symptoms of pulmonary disease. The studies were initially confined to examination of one lung from each patient by the formalin fume-fixation method in the hope that stereoscopic estimations of parenchymal damage would correlate well with the severity of disease in life.

Early in these studies one case was found in the material from each hospital which clinically was diagnosed as severe emphysema with cor pulmonale and right heart failure, but which showed only mild emphysema morphologically plus hypertrophy and dilation of the right heart. Such apparent discrepancies between the clinical and morphologic findings led to additional detailed studies of the bronchi using conventional staining and fixation of sections from the contralateral lung. Since then, a total of four cases of death due to chronic bronchitis and its complications without severe emphysema have been found.

Pulmonary emphysema is most appropriately defined on the basis of morphologic changes in the lungs. Chronic bronchitis, although now a well-defined morphologic entity, is most commonly defined in clinical terms. However, these two diseases frequently give rise to the same manifestations and often occur in the same patient, making their distinction and diagnosis on clinical grounds alone exceedingly difficult. As for the value of pulmonary function tests to aid in differential diagnosis, there is general agreement on the physiologic manifestations of emphysema, but the value of such testing in bronchitis is not clear because few patients with chronic bronchitis without other diseases, as established at autopsy, have had complete studies of respiratory function.

The revival of methods for studying the lung in the inflated state has recently revived hope of clarifying structure-function relationships in these diseases and, thus, of providing an answer to whether tissue changes are related to symptoms.

No morphologic studies have explained the

WILLIAM HENTEL, M.D.; A. N. LONGFIELD, M.D.; THOMAS N. VINCENT, M.D.; GILES F. FILLEY, M.D.; and ROGER S. MITCHELL, M.D. *The American Review of Respiratory Diseases*. February, 1963.

nature of the process by which cyanosis, pulmonary hypertension, and heart failure occur in these diseases. Cases have been recognized recently with marked cyanosis, pulmonary hypertension, and right heart failure, yet with minimal postmortem evidence of alveolar wall destruction. It has been shown, too, that histologic changes in the small pulmonary vessels in emphysema cannot be regarded as the morphologic basis for the pulmonary hypertension.

HISTORY OF CHRONIC ABNORMALITY

If neither reduction in the total number of alveolar capillaries nor changes in the pulmonary arteries can account for the pulmonary hypertension of chronic bronchitis and/or emphysema, it would appear that other factors must be considered. Perhaps the most acceptable explanation today depends upon the fact that patients with fatal chronic bronchitis often have a long history consistent with chronic hypoxia and probably hypercapnia; chronic hypoxia has been shown capable of inducing pulmonary hypertension both under natural and experimental conditions.

Careful study of the air spaces and airways in chronic bronchitis gives the impression that chronic bronchitis is, at least in part, a reversible process, especially if rational therapy could be started before the onset of hypertensive changes in the pulmonary arterioles. The bronchial and bronchiolar walls are thickened and inflamed. The epithelium has undergone metaplasia and may no longer have a normal complement of cilia. The bronchial glands are markedly hypertrophied. However, areas of necrosis, that is, bronchiectasis, are infrequent and limited in extent. Fibrosis and alveolar wall destruction were not severe in the four fatal cases and were localized mostly to the peribronchial areas. Judging from the morphology in these cases, therefore, a favorable effect upon the course of this disease might be expected from early intensive therapy, especially if applied before the onset of irreversible changes. This therapy would include the use of appropriate antimicrobials, postural drainage, tracheal fenestration, and avoidance of repeated infections. Such persons obviously should cease smoking altogether and avoid exposure to other sources of irritating air pollutants. Parenthetically, since many cigarette-smoking bronchitics are virtual cigarette addicts, an almost insoluble therapeutic problem is posed.

The clinical identification of chronic bronchitis in a still treatable phase should be possible. The diagnostic features in the four fatal cases included the following:

(1) Severe chronic cough, especially in the morning when a period of strangling over a small amount of sticky mucus was a fairly regular occurrence.

(2) Repeated deep respiratory infections, slow to improve.

(3) Physiologic manifestations suggestive of diffuse emphysema but with slight differences and with slight to moderate rather than marked increase in total lung capacity, and hypoxia and hypercapnia usually out of proportion to the other findings.

(4) The chest roentgenogram, especially the tomogram, often failed to show the paucity of bronchovascular markings seen in classic diffuse emphysema.

Observers in the United States appear not to have given the attention to this disease which its severity, frequency, treatability, and possible preventability merit. Patients and even physicians are too apt to accept and even foster the common label of "smoker's cough," which is given to the early symptom of the disease. A severe chronic cough should be evaluated carefully, well before any disability has been noticed by the patient. By the time most patients notice any disability, the pulmonary functional loss may well have reached 50 per cent or more.

NEW JERSEY TUBERCULOSIS AND HEALTH ASSOCIATION
15 EAST KINNEY STREET, NEWARK 2, NEW JERSEY

Sustained high-level protection in peptic ulcer



SEARLE all day

SEARLE all night

with b.i.d. dosage

PRO-BANTHĪNE P.A.®

Brand of PROPANTHELINE Bromide

Prolonged-Acting Tablets—30 mg.

Pro-Banthīne P.A. provides the full anticholinergic benefit of Pro-Banthīne® plus the greater convenience and more consistent therapeutic effect of a long-acting dosage form.

Asher[1] has summarized the advantages of prolonged-action dosage forms: "First, they should be of great value in the suppression of night acid secretion in the ulcer patient. Also, in the ulcer patient, with high acid secretion during the day these drugs should be of help when used with regular doses of shorter-acting anticholinergic agents. A third application is in the chronic treatment of certain patients whose tendency to recurrent ulcer has been established."

Pro-Banthīne P.A. offers consistent, sustained anticholinergic effects for more consistent suppression of acid secretion and motility on simple twice or thrice daily dosage in most patients.

G.D. SEARLE & CO.
CHICAGO 80, ILLINOIS
Research in the Service of Medicine

Suggested Adult Dosage:
One tablet at bedtime and one in the morning, supplemented, if necessary, by additional tablets of Pro-Banthīne P.A. or standard Pro-Banthīne to meet individual requirements.

Pro-Banthīne P.A.
is supplied as capsule-shaped, peach-colored tablets of 30 mg. each.

Contraindications:
Glaucoma; severe cardiac disease.

Possible Side Actions:
Xerostomia, mydriasis and, occasionally, hesitancy in urination. Theoretically, a curare-like action may occur.

1. Asher, L. M.: The Choice of Anticholinergic Drugs in the Treatment of Functional Digestive Diseases, Amer. J. Dig. Dis. 4:260-275 (April) 1959.



Before You Buy Any Other Plan Of Lifetime Disability Income Protection . . .

YOU MUST SEE OR HEAR ABOUT

THE DOCTOR'S LIFEGUARD

True Lifetime Protection At Group Rates

- You start to collect benefits in only 26 weeks! Why wait one year?
- You collect the **full amount** of indemnity, for life. Why settle for reduced benefits after age 70?
- Your premium stays the same to age 70. Why be saddled with rates that regularly go up, up, up?

PLUS . . .

The fabulous "first day" hospitalization rider which pays you $250 a week if hospitalized . . . family coverage too!!

This may be the most important prescription you will ever write — one for your own security

SAUL SIEGEL
PHYSICIANS PLANNING SERVICE CORP.
2602 Raymond Commerce Bldg.
Newark 2, N. J. — MA 3-0666
245 Nassau St., Princeton, N. J. — 921-2112

Kindly send complete literature about THE DOCTOR'S LIFEGUARD Lifetime Disability Income Protection Policy.

NAME _____

HOME ADDRESS _____

DATE OF BIRTH _____ CITY _____ STATE _____



vacancy

"The direct cost for caring for the mentally ill is $1.7 billion a year. Workers who become mentally ill lose over half a billion dollars in earnings each year.

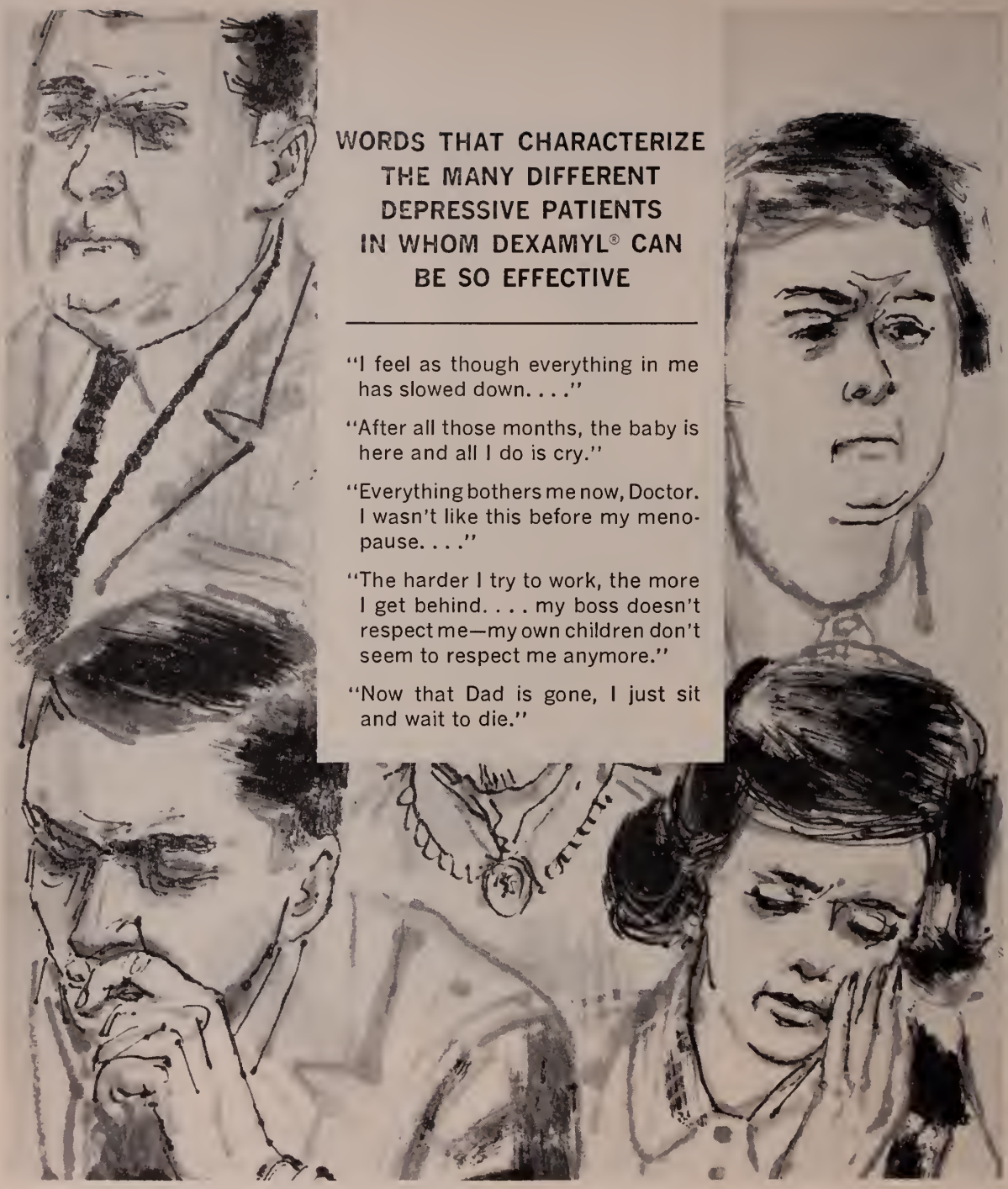
*Staff in one mental hospital recently tried an experiment with 65 patients who had been confined for an average of 13 years. They practiced the best treatment methods now known and, within six months to a year, 37 of these patients were well enough to be discharged. Only eight of the discharged patients failed to hold the gains they had made for at least a year after they left the hospital."**

Hope now, where there was no hope. Drugs which help now, where there were no known drugs which helped—even five years ago. Independent drug research is continuing in this vital area. But, should it be discontinued because the cost must somehow be reflected in the ultimate price of the new drug—if it is to be discovered? Or should the sign read, as it has throughout time in overcrowded mental institutions: "NO VACANCIES."

*U.S. Department of Health, Education and Welfare, Public Health Service Publication No. 813.

This message is brought to you on behalf of the producers of prescription products.

PHARMACEUTICAL MANUFACTURERS ASSOCIATION • 1411 K STREET, N.W. • WASHINGTON, D.C.



WORDS THAT CHARACTERIZE THE MANY DIFFERENT DEPRESSIVE PATIENTS IN WHOM DEXAMYL® CAN BE SO EFFECTIVE

"I feel as though everything in me has slowed down. . . ."

"After all those months, the baby is here and all I do is cry."

"Everything bothers me now, Doctor. I wasn't like this before my menopause. . . ."

"The harder I try to work, the more I get behind. . . . my boss doesn't respect me—my own children don't seem to respect me anymore."

"Now that Dad is gone, I just sit and wait to die."

DEXAMYL® SPANSULE® brand of sustained release capsules

FORMULA: Each 'Spansule' capsule No. 1 contains 10 mg. of Dexedrine® (brand of dextro amphetamine sulfate), and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Spansule' capsule No. 2 contains 15 mg. of 'Dexedrine' (brand of dextro amphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming]. The active ingredients of the 'Spansule' capsule are so prepared that a therapeutic dose is released promptly and the remaining medication, released gradually and without interruption, sustains the effect for 10 to 12 hours.

INDICATIONS: (1) For mood elevation in depressive states; (2) for control of appetite in overweight.

USUAL DOSAGE: One 'Dexamyl' *Spansule* capsule taken in the morning for 10- to 12-hour effect.

SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

CAUTIONS: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these rare instances withdrawal of medication is recommended. It is generally recognized that in pregnant patients all medications should be used cautiously, especially in the first trimester.

SUPPLIED: 'Spansule' capsules No. 1 (1 dot on capsule) and No. 2 (2 dots on capsule), in bottles of 50.
Prescribing information Jan. 1963.

Smith Kline & French Laboratories

SK&F

The Morristown Rehabilitation Center

66 MORRIS STREET **MORRISTOWN, NEW JERSEY**

JEFFERSON 9-3000



NATHAN KAPLAN, M.D., Physiatrist
MARY E. JOHNSON, Chief Therapist

ANN G. McMANUS, R.N.
Director of Nursing Service

AUDREY E. TAHLMORE
Administrator

A 38-bed rehabilitation unit specializing in orthopedic and neurological disabilities. Speech therapy, Occupational therapy and psychological evaluation available.

- - - - - -

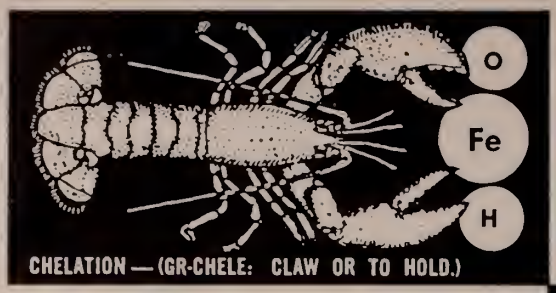
AMERICAN HOSPITAL ASSOCIATION ACCREDITATION
MEMBER NEW JERSEY LICENSED NURSING HOME ASSOCIATION

REPRESENTATIVE FUNERAL DIRECTORS

OF THE STATE OF NEW JERSEY

Special and Dependable Service Day and Night. Special Attention Given to Hospital Calls, Train and Express Shipments.

Place	Name and Address	Telephone
ADELPHIA	C. H. T. Clayton & Son	FReehold 8-0583
BLOOMFIELD	George Van Tassel's Community Funeral Home	PIlgrim 3-1234
CRANBURY	A. S. Cole Son & Co., Main St.	EXport 5-0770
ENGLEWOOD	Greenleaf Funeral Home, Inc., 108 W. Palisade Ave.	LOwell 8-0416
FREEHOLD	Higgins Memorial Home, 20 Center St.	HOpkins 2-0895
METUCHEN	Runyon Mortuary, 568 Middlesex Ave.	LIberty 8-0149
NEWARK	Barrish Funeral Home, 684 Clinton Ave.	ESsex 3-1551—9179
RIDGEWOOD	C. C. Van Emburgh, Inc., 306 E. Ridgewood Ave.	GIlbert 5-0344
SOUTH RIVER	Rezem Funeral Home, 190 Main St.	SOuth River 6-1191
TRENTON	Ivins & Taylor, Inc., 77 Prospect St.	EXport 4-5186



The FIRST Hematinic to Contain BOTH CHELATED IRON and CHELATED MINERALS Assuring a Truly Flavorful, Better Tolerated Iron Therapy.

ADVANTAGES —

Chelated Iron PLUS 4 Chelated Minerals • High Therapeutic Effectiveness • Less Irritation — even on empty stomach • No Tooth Stain • Less Toxic • B-Vitamins for Added Hemopoietic Activity • Pleasant Flavor • Economical

KELATRATE

LIQUID HEMATINIC

CHELATED IRON-MINERALS and VITAMINS

FORMULA —

Each 5 cc. (one teaspoonful) contains:

Iron (as Ferrous Betaine Citrate)	30 mg.
Cobalt (as Cobaltous Betaine Citrate)	0.1 mg.
Manganese (as Manganese Betaine Citrate)	1.0 mg.
Zinc (as Zinc Betaine Citrate)	1.25 mg.
Magnesium (as Magnesium Betaine Citrate)	6.0 mg.
Vitamin B-1	1.5 mg.
Vitamin B-2	1.2 mg.
Vitamin B-12	6.0 mcg.
Niacinamide	10 mg.
Panthenol	10 mg.

In an exceptionally pleasant tasting base.

Comprehensive literature and samples on request.

S. J. TUTAG & CO.
DETROIT 34, MICHIGAN

TUTAG

DUGAN'S

"Bakers for the Home"

New - LITE DIET BREAD

(White Bread Baked Without Shortening)

Calories per Slice 42 Calories per oz. 70

ALSO

SALT-FREE BREAD
GLUTEN AND PROTEIN BREADS
100% WHOLE WHEAT
100% Whole Wheat Crackers

New York Connecticut New Jersey Pennsylvania

"At Your Door or To Your Store
It's DUGAN'S for BETTER Baked Goods"

Phone for Delivery

HUmboldt 2-6007 in Newark

(or your local phone book for branch nearest you)

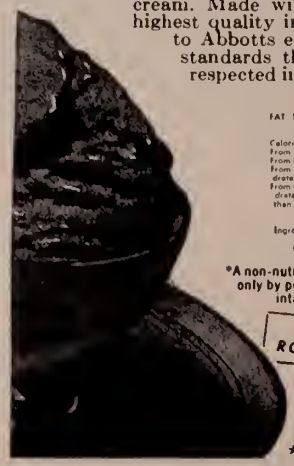
NOW! **DIABETICS CAN ENJOY**
(UNDER MEDICAL ADVICE)

Abbotts

ARTIFICIALLY SWEETENED

ICE CREAM

Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards — standards that are most highly respected in the dairy industry



COMPOSITION
FAT 10.52% PROTEIN 3.71%
CARBOHYDRATES 20.40%

Calories — Per 100 Gm.	Aver. Oz	Fluid Oz
From Fat	94.68	26.84	16.25
From Protein	14.84	4.21	2.55
From Carbohydrates as Lactose	20.24	5.74	3.47
From Carbohydrates other than Lactose	61.66	17.48	10.58
	191.42	54.27	32.85

Ingredients Cream, Milk, Sorbitol, Stabilizer and 0.11% Cyclamate Calcium*

*A non-nutritive artificial sweetener for use only by persons who must restrict their intake of ordinary sweets.

IN HANDY ROUND PINTS

At Abbotts and Jane Logan Dealers
Abbotts Dairies

LONG TERM AUTO LEASING

. . . A SERVICE ESPECIALLY PLANNED FOR DOCTORS!

M.D. PLATES FREE, TOO!

AAL LONG TERM SINGLE CAR AND FLEET RENTALS

Call ORange 6-7137 or

MAIL COUPON TODAY

Lease a brand new Cadillac or other fine car from American and you'll never **buy** again. Save money, time and trouble. One modest monthly payment takes care of everything . . . insurance, maintenance, repairs, depreciation . . . and the payments are 100% tax deductible! Borrow a car—free of charge—in case of accident or breakdown.

INCLUDES

- Registration and plates
- Full maintenance
- Insurance

Liability $250/$500,000
Property damage $20,000
Deductible collision,
fire and theft

AMERICAN AUTO LEASING COMPANY
120 Halsted St., East Orange, N. J.
Please send me the AAL Long Term Leasing Plan.

Wide Selection of '63 Models

Special requirements _____

_____

Name _____

Address _____

City _____ State _____

ALL YOU BUY IS GAS AND OIL

ASK FOR BROCHURE

AAL

AMERICAN AUTO LEASING COMPANY

120 Halsted Street, East Orange, New Jersey • ORange 6-7137

Ranch Type - Luxurious

THE PARKWAY NURSING HOME, INC.



1201 PARKWAY AVE.

Trenton, N. J.

882-6900

No Steps!
New audio-visual intercom system from every patient to Nurses.

One of New Jersey's newest, most modern and completely equipped Nursing and Convalescent Homes, catering to the Convalescent, Aged, and Chronically Ill.

Referring physician has full medical privileges
Complete 24-hour general nursing care
Physical rehabilitation department
Beauty parlor — air-conditioned dining room, lounge, and lobby — spacious patios

Ultra modern interiors with artistic color scheme
Stainless steel kitchen tiled to ceiling
Special diets — planned social and recreational activities

Residential Section
Reasonable Rates

The Parkway Nursing Home

NEW JERSEY STATE LICENSED

MEMBER OF AMERICAN NURSING HOME ASSOCIATION

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

Place	Name and Address	Telephone
BERGENFIELD	Horn's Pharmacy, 475 So. Washington Ave.	DUmont 4-1119
BLOOMFIELD	Burgess Chemist, 56 Broad St.	PIlgrim 3-1005
CLOSTER	Mid Town Pharmacy, 237 Closter Dock Road	PO. 8-0070
DUMONT	Lenrow's Pharmacy, Inc., 10 W. Madison Ave.	DUmont 4-0842-1500
EDISON TOWNSHIP	Walter's Pharmacy, 1034 Amboy Ave.	LIberty 8-2614
EMERSON	Emerson Pharmacy, 201 Kinderkamack Road	COlfax 2-4999
HIGHLANDS	Highlands Pharmacy, 148 Bay Ave.	872-1550
JERSEY CITY	J. B. Feinberg Pharmacy, 659 Newark Ave.	OLdfield 3-6376
JERSEY CITY	Honiberg Drug & Surgical Supply Co., 618 Newark Ave.	SWarthmore 8-6700
JERSEY CITY	Lauria's Pharmacy, 768 West Side Ave.	HEnderson 3-1519
KEYPORT	Sav-On-Drugs, J. Meisler, opp. Post Office.	COlfax 4-0904
MILLTOWN	Milltown Pharmacy, 21 No. Main St.	MIlltown 8-0081
MILLVILLE	Richard H. Knowles Pharmacy, 600 No. High St.	TAylor 5-0721
MORRISVILLE, PA.	Pryor's Pharmacy, Bridge St. & Penna Ave.	Cypress 5-7416
MOUNT HOLLY	Mount Holly Pharmacy, 64 Main St.	AMherst 7-0453
NEWARK	Giannotto's Pharmacy, 195 First Ave.	HUmboldt 2-8220
NEWARK	Marquier's Pharmacy, Sanford and So. Orange Aves.	ESsex 3-7721
NEW BRUNSWICK	Bode Pharmacy, 120 French St.	KIlmer 5-2676
NEW BRUNSWICK	Tobin's Drug Store, 335 George St.	CHarter 9-0780
NEW BRUNSWICK	Zaiac's Pharmacy, 225 George St.	KIlmer 5-0582
OCEAN CITY	Selvagn's Pharmacy, 862 Asbury Ave.	OCean City 3535
ORANGE	Highland Pharmacy, 536 Freeman St.	ORange 3-1040
PASSAIC	Wollman Pharmacy, 143 Prospect St.	PRescott 9-0081
PATERSON	Vallario's Pharmacy, 357 Totowa Ave.	ARmory 4-2139
PAULSBORO	Nastase's Pharmacy, 762 Delaware St.	PAulsboro 8-1569
RAHWAY	Kirstein's Pharmacy, 74 East Cherry St.	FUlton 8-0235
RIDGEFIELD PARK	Lloyd's Prescriptions, 209 Main St.	DIamond 2-8383
RUMSON	Rumson Pharmacy, W. E. Fogelson	842-1234
SOUTH AMBOY	Madura Pharmacy, 115 N. Broadway	PArkway 1-1732
SOUTH AMBOY	Peterson Pharmacy, 132 No. Broadway	PArkway 1-0137
TRENTON	Adam & Sickles, State & Prospect Sts.	OWen 5-6396
TRENTON	Episcopo's Pharmacy, Chambers & Liberty Sts.	EXport 3-3017
TRENTON	Foy's Drug Store, 3024 So. Broad St.	EXport 3-2367
UNION	Perkins Union Center Pharmacy	MUrdock 6-0877
WEST NEW YORK	The Owl Pharmacy, 6611 Bergenline Ave.	UNion 5-0384
WEST ORANGE	West Orange Pharmacy, 443 Main St.	ORange 4-9824
WRIGHTSTOWN	Bowen's Pharmacy, 152 Fort Dix Road	RAymond 3-2176

"Prescribe with Confidence"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR
FOR MEN - WOMEN - CHILDREN



SOLD ON Rx ONLY
OUTFLAIR SHOES
FOR CLUB FEET

177A JEFFERSON AVE.
PASSAIC, N. J.

69 WESTWOOD AVE.
WESTWOOD, N. J.

350 MAIN ST.
HACKENSACK, N. J.

Dennis Brown Splints — in all sizes — carried in stock

FAIR OAKS HOSPITAL

SUMMIT, NEW JERSEY

CRestview 7-0143

OSCAR ROZETT, M.D.
Medical Director

MOLLIE KENNEDY, R.N.
Director, Nursing Service

EDWARD R. DUTY, M.D.
Clinical Director

N. M. JANI, M.D.
S. D. ESTRADA, M.D.
Associate Psychiatrists

THOMAS P. PROUT, JR.,
Administrator

AN 85 BED INTENSIVE TREATMENT PSYCHIATRIC UNIT

Certified by
The Joint Commission on Accreditation of Hospitals
The Central Inspection Board, American Psychiatric Assn.







Flavoring Improves Palatability of Acidophilus Milk

In the treatment of acne vulgaris and such gastro-intestinal disorders as simple chronic constipation and simple diarrhea, patient resistance to ingestion of Acidophilus may be controlled if flavor is improved by stirring 1 to 2 teaspoons of Jell-O powder into each glass of Acidophilus Milk before serving. Most popular flavors are raspberry, cherry, orange-pineapple, blackberry, and strawberry. For patients on low-calorie diets, substitute D-Zerta for Jell-O. Add a few drops of Sweeta or Sweet-10 to the flavored Acidophilus for a sweeter drink.

WALKER-GORDON ACIDOPHILUS

2% butterfat, made from Walker-Gordon Certified Milk cultured with 300-500 million acidophilus bacilli per ml. Available through leading milk dealers.

WALKER-GORDON CERTIFIED MILK FARM, Plainsboro, N. J.

SWinburne 9-1234 (N. Y. WAlker 5-7300; Phila. PEnnypacker 5-3465)

How Lyons Institute Serves the Medical Profession

For the past eleven years Lyons Institute of Medical, Dental and X-ray Technology has been training high school graduates to serve the medical profession as:

MEDICAL TECHNOLOGIST • MEDICAL TECHNICIAN • MEDICAL ASSISTANT
X-RAY TECHNICIAN • MEDICAL SECRETARY

Many hundreds of our graduates are employed by physicians, hospitals, clinics, laboratories, pharmaceutical concerns and private industry. If you are seeking qualified personnel in any one of the above fields, our free Placement Bureau is at your Service.

LYONS INSTITUTE of MEDICAL, DENTAL & X-RAY TECHNOLOGY

900 BROAD STREET, NEWARK 2, N. J. **Telephone: MItchell 2-3420**

Director, CRAIG R. GARTH, Captain, U.S. Navy (Ret.)
Approved by the New Jersey State Department of Education

CHANGE OF ADDRESS

In the event of a change of address or failure to receive THE JOURNAL regularly fill out this coupon and mail at once to

THE MEDICAL SOCIETY OF NEW JERSEY, P. O. Box 904, Trenton 5, N. J.

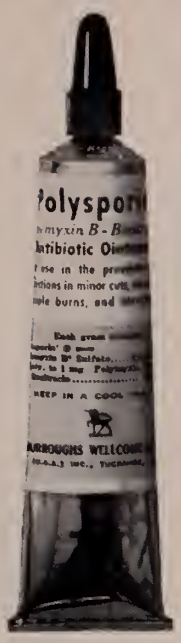
Change my address on mailing list

From .....

To .....

Date ..... Signed ..... M.D.

in treating topical infections, no need to sensitize the patient



USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN ANTIBIOTIC OINTMENT

broad-spectrum antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **Supplied:** in ½ oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

---

a program of
postgraduate education on

CARDIORENAL MECHANISMS & DISEASES

Wednesday & Thursday, June 5, 6, 1963

Etiologic Considerations of Hypertension
Primary and Secondary Aldosteronism
Catecholamine Metabolism
Renovascular Hypertension
Management of Hypertensive Cardiovascular Disease
Pharmacology of Diuretic Drugs
Management of Edema
Uremia
Artificial Dialysis
Acidosis and Alkalosis
Electrolyte Depletion Syndromes
Management of Electrolyte Imbalance

FOR INFORMATION CONTACT
ALBERT N. BREST, M.D.

HAHNEMANN MEDICAL COLLEGE AND HOSPITAL
230 NORTH BROAD STREET
PHILADELPHIA 2, PENNSYLVANIA

WOULD YOUR OFFICE RENT STOP . . . IF YOU WERE HOSPITALIZED FOR SIX MONTHS?

Of course not! That's just one of the reasons why wise physicians and dentists take advantage of broad new benefits available in our "Loss of Time" policy.

We pay YOU each month when you are hospitalized or disabled.

For full details, at no obligation, simply send the coupon below.

PHYSICIANS MUTUAL INSURANCE CO.
formerly
Physicians Casualty and Health Associations
"The Doctors Company"
Insuring Physicians & Dentists for 60 years.

Physicians Mutual Insurance Company
115 So. 42nd Street
Omaha 31, Nebraska

Please send details on your "Loss of Time" policy.

NAME_____ AGE_____

ADDRESS_____

CITY_____ STATE_____

CLASSIFIED ADVERTISEMENTS

WANTED FOR SALE TO LET
SITUATIONS, ETC.

Send replies to box number c/o The Journal
P. O. Box 904, Trenton 5, N. J.

$3. for 25 words or less; additional words 5c each
Forms close 15th of the preceding Month.

TWO HOUSE PHYSICIANS WANTED—For one year beginning July 1, 1963, in 130-bed general hospital; one for medical patients and one for surgical patients. One year accreditation in general surgery. University teaching affiliations. Salary—$10,000 plus benefits. State license or ECFMG certificate required. Apply to: William Y. Inouye, M.D., Jeanes Hospital, Philadelphia 11, Pennsylvania.

STAFF PHYSICIANS—For JCAH approved county chest disease hospital; must have New Jersey license. Salary open, fringe benefits, maintenance at nominal cost. Contact Irving Ocheret, M.D., Superintendent, Essex County Sanatorium, Verona, New Jersey.

YOUNG INTERNIST—Gastro-enterologist. University-trained, board eligible. Desires association with another internist or small group. Training includes gastro-intestinal radiology. Write Box No. 61, c/o THE JOURNAL.

ANESTHESIOLOGIST—Fellow and Diplomate, desires to relocate in large or small hospital as departmental head. Will consider solo or group. Write Box 55, c/o THE JOURNAL.

SURGEON—Young, excellent university training. Awaiting orals for board certification. Desires good association in northeast. Write Box 62, c/o THE JOURNAL.

AVAILABLE—Active general and obstetrical practice being covered since sudden death of well-known physician. A fully equipped, eight-room office under modern seven-room residence. Twenty minutes from New York City. Three open staff hospitals within ten minutes. Will introduce and arrange terms. Write to Mrs. M. L. Kimmel, 3342 Hudson Boulevard, Jersey City 7, New Jersey; or call OL 9-8220.

NEEDED—Two physicians in different specialties to rent new offices adjacent to two general practitioners and dentist in Brick Township. Rentals under $100 monthly. Reply Box 44, c/o THE JOURNAL.

PHYSICIANS WANTED—Male and female, licensed, for children's camps, July-August. Good salary, free placement. 350 member camps. Department p. Association Private Camps, 55 West 42nd Street, New York 36, New York.

RADIOLOGICAL PRACTICE FOR SALE—Paterson, New Jersey. For the cost of office building, diagnostic, and therapy equipment, lead-lined rooms; two tenants' rentals more than enough to cover taxes and other expenses. Reasonable terms. Would rent also. Write Box No. 49, c/o THE JOURNAL.

EQUIPMENT AND PRACTICE FOR SALE — Newark, long-established, broad general practice. Completely equipped modern office, modalities, x-ray, etc. Write Box No. 64, c/o THE JOURNAL.

POSITION WANTED—Medical Assistants and Secretaries. Laboratory and X-Ray Techs. Well-trained and highly-qualified personnel (male and female) available. Phone CH 2-2330, Ext. 17, Placement Department, or write Physician Director, Eastern School for Physicians' Aides, Department 7, 85 Fifth Avenue, New York 3, New York.

FOR SALE—Lovely colonial house, 4 bedrooms, 3½ baths, modern kitchen, attached 5-room wing with complete bath suitable for office or apartment. In prime residential area of Red Bank—river rights. Price: $52,000. Write Box No. 63, c/o THE JOURNAL.

PHYSICIAN'S OFFICE FOR SALE—Fully equipped for X-ray and lab tests. Also 6-room living quarters plus 3-room apartment in City of Bridgeton, New Jersey. Call—Simon Real Estate Agency, Inc., 500 Landis Avenue, Vineland, New Jersey, 692-5850 or 691-6017.

FOR SALE—Roseville Avenue, Newark, New Jersey, between Park and 4th Avenues. Newly-painted; brick, shingle; 13 rooms, 2 baths; large foyer hall; maple floors; new oil burner; 220 electricity; 2-car brick garage, large parking area; perfect for professional and home. Phone HU 2-2380 after 4:00 p.m.

FOR SALE—Residence, apartment, and adjoining professional offices in a central New Jersey community with tremendous growth potential. Established doctor's location, highly desirable for specialized practice. For complete details consult Claudia Pascale, Realtor, 68 North Bridge Street, Somerville. RA 2-1032.

OFFICE FOR RENT—Irvington, New Jersey, opposite hospital, was physician's office for over 20 years. Records of recently deceased physician available. Will rent either fully equipped or unequipped. Bus lines stop at door. Phone SO 3-3663 or SO 3-0277.

FOR RENT—Demarest, New Jersey (Bergen County) (7 miles George Washington Bridge). Medical Office. Brand-new building. Waiting, examing, consulting rooms; nurses station. Available August. LO 8-8687.

FOR RENT—Tenafly, New Jersey (5 miles George Washington Bridge). Doctor's office and house, corner location. Opportunity to practice with minimal outlay. Lease. LO 8-8687.

CLASSIFIED ADVERTISEMENTS

IRVINGTON—600 square foot suite remaining in new professional building, presently occupied by dentist, allergist, optometrist, and speech therapist. 1146 Stuyvesant Avenue. ES 3-1073, MU 6-0787.

OFFICE SUITES AVAILABLE—New medical building, Kinnelon, New Jersey. Area in need of internist, surgeon, obstetrician, pediatrician. Ricker & Gaugler Brokers, Butler, New Jersey. TE 8-0400.

WEST ESSEX MEDICAL CENTER—Suites available to specialists. Full or part-time basis. Excellent location and facilities for suburban practice. Write: Stanley S. Fieber, M.D., 588 Eagle Rock Avenue, West Orange, New Jersey; or call RE 1-0011.

PROFESSIONAL OFFICE SPACE—Ground floor, new building. Route 23. Call CE 9-2082.

STIRLING PROFESSIONAL BUILDING—Doctor needed in new 5½-room suite that is adjoining an established dentist. Can be shared. Paneled waiting room, planned plumbing, parking, heat and water supplied, moderate rent. Call MI 1-2797-M.

HOME-OFFICE-PRACTICE FOR SALE—Short Hills, New Jersey, near new Saint Barnabas Hospital. General practitioner and internist leaving large practice for full-time research. Lovely 6-year-old home with 4 bedrooms, plus 8-room suite of completely equipped, air-conditioned offices; ample parking; adaptable for two doctors. Contact Warren D. Collins, Realtor, 56 Brick Church Plaza, East Orange, New Jersey. OR 6-9340.

IDEAL PROPERTY—For doctors, nursing home, or medical center. Property 100′ x 154′. Present living quarters: 5½ rooms with bath and center hall. Breezeway enclosed with heat 10′-8″ x 28′-0″. Building attached 24′-0″ x 56′-8″ with heat and bath. Buildings all masonery in very good condition. Plenty of parking in front and rear. Location zoned business approximately center of town. At 1999 Route 88 Brick Town, Ocean County, New Jersey. Telephone 899-3269. Call evenings. Must see to appreciate. Asking price is $32,000.

NEW YORK FERTILITY INSTITUTE

For the Investigation of Problems of Human Infertility

The Institute provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

Patients are accepted by the Institute only by doctor referral and returned to the referring physician after appropriate studies have been made, together with a complete detailed report of the findings of the Institute and its consultants and recommendations for therapy. Literature on request.

123 East 89th Street, N. Y. 28, N. Y.

Phone: TR 6-9300

THUMBSUCKING

since infancy caused this malocclusion.



THUM TRADEMARK

THUM helped break the habit and teeth returned to normal position.

THUM discourages Nail Biting too

70¢ At Your Drug Store

RADON • RADIUM

SEEDS • IMPLANTERS • CERVICAL APPLICATORS

THE RADIUM EMANATION CORPORATION

GRAYBAR BUILDING • NEW YORK 17, N. Y.

Wire or Phone MUrray Hill 3-8636 Collect





the patient under physiologic stress...

a prime candidate for

MYADEC®

high-potency vitamin formula with minerals

It is generally agreed that vitamin requirements are often increased after surgery, during acute or chronic stages of disease, throughout convalescence, and at other times of physiologic stress. Moreover, nutritional intake may be inadequate as a result of restricted diets. In conditions such as these, MYADEC can provide an extra measure of support. Just one capsule a day provides 9 vitamins in therapeutic potencies, plus a supplement of selected minerals normally present in body tissues. MYADEC is also useful for the prevention of vitamin deficiencies in patients whose usual diets are lacking in these important food factors.

Each MYADEC capsule contains: **Vitamins:** Cyanocobalamin—5 mcg.; Riboflavin—10 mg.; Pyridoxine hydrochloride—2 mg.; Thiamine mononitrate—10 mg.; Nicotinamide—100 mg.; Ascorbic acid—150 mg.; Vitamin A—(7.5 mg.) 25,000 units; Vitamin D—(25 mcg.) 1,000 units; *d*-alpha-tocopheryl acetate concentrate—5 I.U. **Minerals:** Iodine—0.15 mg.; Manganese—1 mg.; Cobalt—0.1 mg.; Potassium—5 mg.; Molybdenum—0.2 mg.; Iron—15 mg.; Copper—1 mg.; Zinc—1.5 mg.; Magnesium—6 mg.; Calcium—105 mg.; Phosphorus—80 mg. (Minerals supplied as potassium iodide, dibasic calcium phosphate, sodium molybdate, and the sulfates of manganese, cobalt, potassium, iron, copper, zinc, and magnesium.) 13663

Bottles of 30, 100, and 250.

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan



Formerly nervous and tense, now better able to...

enjoy her family

This, in essence, is what happens when you place a patient on Librium (chlordiazepoxide HCl). Since this agent generally relieves anxiety and tension without dulling mental clarity or inducing drowsiness, most patients become better able to function normally, take an active interest in family and surroundings, meet and solve daily problems. This antianxiety agent is virtually free from extrapyramidal side effects, and does not produce or deepen depression.

DOSAGE: **Oral**—Usual adult dose in mild to moderate anxiety and tension is 5 or 10 mg, 3 or 4 times daily; in severe anxiety and tension, 20 or 25 mg, 3 or 4 times daily. **Parenteral**—To control acute conditions, the usual initial adult dose is 50 to 100 mg I.M. or I.V.; not more than 300 mg should be given during a 6-hour period. □ SIDE EFFECTS: **Oral**—Drowsiness and ataxia, usually dose-related, have been reported in some patients—particularly the elderly and debilitated. Paradoxical reactions, i.e., excitement, stimulation, elevation of affect and acute rage, have been reported in psychiatric patients; these reactions may be secondary to relief of anxiety and should be watched for in the early stages of therapy. Other infrequent dose-related side effects have included isolated instances of minor skin rashes, minor menstrual irregularities, nausea, constipation, increased and decreased libido. **Parenteral**—Following parenteral administration some patients may become drowsy or unsteady. The injectable form has occasionally produced mild, transitory fluctuations of blood pressure. □ PRECAUTIONS: **Oral**—In elderly, debilitated patients, limit dosage to smallest effective amount to preclude development of ataxia or oversedation (not more than 10 mg per day initially, to be increased gradually as needed and tolerated). Until the correct maintenance dosage is established, patients receiving this agent should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Although this agent is a valuable aid in acute and chronic alcoholism, caution patients about possible combined effects with alcohol. Caution should be exercised in administering it to addiction-prone individuals. Careful consideration should be given to the pharmacology of any agents to be employed with Librium (chlordiazepoxide HCl)—particularly the MAO inhibitors and phenothiazines. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests may be advisable in protracted treatment. **Parenteral**—Parenteral administration is indicated primarily in acute states, and patients receiving this form of therapy should be kept under observation, preferably in bed, for a period of up to three hours. Ambulatory patients should not be permitted to operate a vehicle following injection. The usual precautions of reduced dosage should be observed when treating patients with impaired renal or hepatic function. The injectable form should not be given to patients in shock or comatose states. Reduced dosage (usually 25 to 50 mg) should be used for elderly or debilitated patients, and for children.

Anxiety and tension relieved
Alertness maintained

Librium®
(chlordiazepoxide HCl)

the successor
to the tranquilizers

ROCHE

THE Journal OF

THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since 1904
Copyright 1963 by The Medical Society of New Jersey

Entered as second-class matter Sept. 5, 1906, at the post office, Orange, N. J., under Act of March 3, 1879
Second Class Postage Paid at Orange, N. J.

VOL. 60, NO. 6 JUNE, 1963 50 Cents - $5.00 PER YEAR

CONTENTS—Pages 223 to 254

EDITORIALS— Page

Jerome G. Kaufman: Our New Leader 223

Introducing Pat Booth 224

ORIGINAL ARTICLES—

Measuring Up To Responsibility and Leadership—Jerome G. Kaufman, M.D., Maplewood 225

Medical and Legal Responsibility in Clinical Research—William Furst, M.D., East Orange and William Furst, LL.B., Newark 229

Role of the Family Physician in Accident Prevention—Samuel C. Southard, M.D., Ventnor 232

Treatment of the Ambulatory Schizophrenic—Robert S. Garber, M.D., Belle Mead 235

ORIGINAL ARTICLES— page

Artificial Production of Intra-Arterial Thrombosis—Hugo O. Gelmann, M.D., Stuart R. Silver, M.D., A. M. Sabety, M.D., Orange 241

Heterotopic Pregnancy—Sidney Cohn, M.D., and Paul Grossbard, M.D., Passaic 244

STATE ACTIVITIES—

Radiation Protection 228
Radioisotope Training 231
Vaccina Immune Globulin 240
Appreciation to Dr. Allman 245
Introduction of New President 246
Address of Retiring President 247
Golden Merit Awards 248
Trustees' Meeting: April 21, 1963 249
Academy of Medicine Library Acquisitions 41A

BOOK REVIEWS 251

RESPIRATORY DISEASE ABSTRACTS 253

Roster of Officers and Committee Chairmen, Advertising Page 3A

The Medical Society of New Jersey Endorsed Plans of

ACCIDENT AND HEALTH INSURANCE
MAJOR MEDICAL EXPENSE INSURANCE
TERM LIFE INSURANCE

****SIX POINT, HIGH LIMIT ACCIDENT INSURANCE**
(Accidental Death, Dismemberment and other Accident Benefits)

Income Protection (Accident and Sickness Insurance)

$1,200 a month new maximum Basic total disability benefit

ACCIDENT: from 1st day, up to 5 years (Partial Accident Disability, half benefit up to six months)
SICKNESS: from 8th day, up to 2 years

$600 a month new maximum Extended total disability benefit, continuing benefits beyond basic coverage.

ACCIDENT: extended to LIFE
SICKNESS: extended through SEVENTH year

Major Medical

$10,000 maximum for Covered Expenses for each accident or sickness, covering member, spouse, and eligible children. $500 deductible, 20% co-insurance.

Life

$10,000 to **$50,000** of Convertible Term Life Insurance.
(Guaranteed exchangeable at any time into Permanent Cash Value life insurance)

Applications for initial $10,000 policy and additional $10,000 policies up to $50,000 total under this plan considered during the month of November each year*.

** **SIX POINT, HIGH LIMIT ACCIDENT INSURANCE**

Up to $200,000 Six Point, High Limit Accident Insurance, covering accidental death, dismemberment, loss of sight, total and permanent disability, exposure and disappearance for member.

Up to $100,000 for spouse (without disability benefit).

Applications are subject to age limits and other company rules and regulations for acceptance of risks. New members have special privileges during the first few months of membership; ask for specific details if you were recently elected and have not received notification from us.

Information and claim service are as close as your telephone.

E. & W. BLANKSTEEN

E. & W. Blanksteen Agency, Inc.

75 MONTGOMERY STREET **JERSEY CITY 2, NEW JERSEY**

DElaware 3-4340

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATON, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.
EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154
(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

OFFICERS

President, Jerome G. Kaufman, M.D. ..... Maplewood
President-Elect, Charles H. Calvin, M.D. ..... Perth Amboy
First Vice-President, John J. Bedrick, M.D. .....Bayonne
Second Vice-President, Joseph R. Jehl, M.D. ..... Clifton
Secretary, Marcus H. Greifinger, M.D. .....Newark
Treasurer, Daniel F. Featherston, M.D. ..... Asbury Park

Richard I. Nevin, *Executive Director* ..... Trenton
Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton

TRUSTEES

Samuel J. Lloyd, M.D., *Chairman* (1966) ..... Trenton
Nicholas A. Bertha, M.D., *Secretary* (1965) ..... Wharton
Jerome G. Kaufman, M.D. ..... Maplewood
Charles H. Calvin, M.D. ..... Perth Amboy
John J. Bedrick, M.D. ..... Bayonne
Joseph R. Jehl, M.D. ..... Clifton
Marcus H. Greifinger, M.D. ..... Newark
Daniel F. Featherston, M.D. ..... Asbury Park
Louis S. Wegryn, M.D. ..... Elizabeth
Louis F. Albright, M.D. (1964) ..... Spring Lake
Louis K. Collins, M.D. (1964) ..... Glassboro
Thomas C. DeCecio, M.D. (1965) ..... Cliffside Park
Joseph P. Donnelly, M.D. (1966) ..... Jersey City
Lloyd A. Hamilton, M.D. (1965) ..... Lambertville
Frank J. Hughes, M.D. (1966) ..... Gloucester
John F. Kustrup, M.D. (1966) ..... Trenton
Emanuel M. Satulsky, M.D. (1964) ..... Elizabeth
Carl N. Ware, M.D. (1965) ..... Ocean City

COUNCILORS

First District (Essex, Morris, Union, and Warren Counties) ..... Thomas S. P. Fitch, M.D., Plainfield (1966)
Second District (Bergen, Hudson, Passaic, and Sussex Counties) ..... John L. Olpp, M.D., Englewood (1965)
Third District (Hunterdon, Mercer, Middlesex, and Somerset Counties) ..... Albert F. Moriconi, M.D., Trenton (1964)
Fourth District (Burlington, Camden, Monmouth, and Ocean Counties) ..... E. Vernon Davis, M.D., Moorestown (1966)
Fifth District (Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties) .... Isaac N. Patterson, M.D., Westville (1965)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell, M.D. (1964) ..... Asbury Park
William F. Costello, M.D. (1963) ..... Dover
Joseph P. Donnelly, M.D. (1964) ..... Jersey City
Marcus H. Greifinger, M.D. (1964) ..... Newark
Luke A. Mulligan, M.D. (1964) ..... Leonia
Isaac N. Patterson, M.D. (1963) ..... Westville

Alternates

F. Clyde Bowers, M.D. (1964) ..... Mendham
Frank J. Hughes, M.D. (1964) ..... Gloucester
Joseph R. Jehl, M.D. (1964) ..... Clifton
John F. Kustrup, M.D. (1964) ..... Trenton
Elton W. Lance, M.D. (1963) ..... Rahway
John L. Olpp, M.D. (1963) ..... Englewood

DELEGATES TO OTHER STATES

New York—William F. Costello, M.D. (1963) ..... Dover
Connecticut—Lloyd A. Hamilton, M.D. (1963) .. Lambertville
New York—G. Ruffin Stamps, M.D. (1963) .... Atlantic City
Connecticut—S. Eugene Dalton, M.D. (1963) ..... Ventnor

CHAIRMEN — 1963 - 1964

Annual Meeting ..... Edward E. Seidmon, M.D., Plainfield
Cancer Control ..... John L. Olpp, M.D., Englewood
Child Health ..... Robert E. Jennings, M.D., South Orange
Chronically Ill and the Aging ..... Matthew E. Boylan, M.D., Jersey City
Constitution and Bylaws Revision ..... Louis F. Albright, M.D., Spring Lake
Credentials ..... Marcus H. Greifinger, M.D., Newark
Disaster Medical Care ..... Jack R. Karel, M.D., Hillside
Finance and Budget ..... Carl N. Ware, M.D., Ocean City
Hearing and Speech ..... James H. Spillane, M.D., Phillipsburg
Honorary Membership ..... F. Clyde Bowers, M.D., Mendham
Legislation ..... Jesse McCall, M.D., Newton
Maternal and Infant Welfare ..... John D. Preece, M.D., Trenton
Medical Defense and Insurance ..... Daniel F. Featherston, M.D., Asbury Park
Medical Education ..... Sherman Garrison, M.D., Bridgeton
Medical Services ..... Irving Klompus, M.D., Bound Brook
Medical Student Loan Fund ..... Luke A. Mulligan, M.D., Leonia
Mental Health ..... Robert S. Garber, M.D., Belle Mead
Nursing Education ..... Irving M. Levitas, M.D., Westwood
Occupational Health ..... Delma W. Caldwell, M.D., Linden
Publication ..... George B. Sharbaugh, M.D., Trenton
Public Health ..... John B. Fuhrmann, M.D., Flemington
Public Relations ..... John F. Kustrup, M.D., Trenton
Rehabilitation ..... Elmer J. Elias, M.D., Morristown
Retirement Plan for Physicians ..... Nicholas E. Marchione, M.D., Vineland
Scientific Exhibits ..... Milton Ackerman, M.D., Margate City
Scientific Program ..... Herschel S. Murphy, M.D., Roselle
Traffic Safety ..... William L. Sprout, M.D., Salem
Vision ..... Ralph E. Siegel, M.D., Perth Amboy
Woman's Auxiliary Advisory ..... George O. Rowohlt, M.D., Dumont
Workmen's Compensation ..... Joseph A. Lepree, M.D., Elizabeth



diarrhea is a threefold challenge—

HYPERMOTILITY···CRAMPS···ANXIETY

Donnagel provides the antispasmodic-sedative action of Donnatal,® plus toxin adsorbents and demulcents—for effectively controlling gastrointestinal hypermotility, decreasing spasm, relieving pain and easing mild anxiety.

SIDE EFFECTS: On increased dosage blurred vision, dry mouth or difficult urination may occasionally occur.

PRECAUTIONS: Use with caution in incipient glaucoma or prostatic hypertrophy.

CONTRAINDICATIONS: Do not administer to patients with acute glaucoma, or to patients hypersensitive to any component.

Donnagel®

Robins

Each fluidounce (30 cc.) contains:

Kaolin	6.0 Gm.
Pectin	142.8 mg.
Donnatal—Natural belladonna alkaloids	
hyoscyamine sulfate	0.1037 mg.
atropine sulfate	0.0194 mg.
hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

(Warning: May be habit-forming)

Available also as DONNAGEL®-PG...same formula plus powdered opium USP 24 mg. (equiv. to paregoric 6 ml.).
(Warning: May be habit-forming)

A. H. ROBINS CO., INC., Richmond 20, Virginia

there is nothing "new" about Thorazine®



brand of

chlorpromazine

In the nine years since it became available to American physicians, Thorazine (chlorpromazine, SK&F) has been more widely used, more thoroughly investigated and more extensively documented than any other agent of its type.

Its actions, effects—and side effects—are well known throughout the medical profession. Its efficacy has been clearly demonstrated. And when properly used, its advantages far outweigh any possible disadvantages.

This is why there is nothing "new" about Thorazine (chlorpromazine, SK&F). This is why it remains the first choice in many conditions—and the standard against which other agents are inevitably compared.

This is why it is one of the fundamental drugs in medicine.

SMITH KLINE & FRENCH
LABORATORIES, PHILADELPHIA

SK&F



For dramatic restoration

WINSTROL®

brand of STANOZOLOL

Oral anabolic therapy with this new physiotonic helps restore the patient's: positive protein metabolism; confidence, alertness and sense of well-being.

WINSTROL (stanozolol/Winthrop), a heterocyclic steroid, combines highest potency* with outstanding tolerance, stimulates appetite and promotes weight gain... restores a positive metabolic balance. It counteracts the catabolic effects of concomitant corticosteroid or ACTH therapy. WINSTROL (stanozolol/Winthrop) rebuilds body tissue while it builds strength, confidence and a sense of well-being in conditions associated with excess protein breakdown, insufficient protein intake and inadequate nitrogen and mineral retention.

Side Effects and Precautions: Prolonged administration can produce mild hirsutism, acne or voice change. In an occasional patient, edema has been observed and in young women the menstrual periods have been milder and shorter. These side effects are reversible, and patients receiving prolonged treatment should be examined and questioned periodically so that, should side effects appear, the dosage may be reduced or administration of the drug discontinued for a time.

In patients with impaired cardiac and renal function, there is the possibility of sodium and water retention. Liver function tests may reveal an increase in bromsulphalein retention, particularly in elderly patients. In such cases, therapy should be discontinued. Although it has been used in patients with cancer of the prostate, its mild androgenic activity is considered by some investigators to be a contraindication.

Dosage: Usual adult dose, 1 tablet t.i.d. before or with meals; young women, 1 tablet b.i.d.; children (school age): up to 1 tablet t.i.d.; children (preschool age): ½ tablet b.i.d. Available as scored tablets of 2 mg. in bottles of 100. For best results, administer with a high protein diet.

*ANIMAL DATA

Rx WINSTROL (stanozolol/Winthrop) whenever anabolic therapy is indicated

Winthrop

Winthrop Laboratories, New York 18, New York

New from SAUNDERS

Three New Editions

New (11th) Edition!
Beeson & McDermott—Cecil-Loeb
TEXTBOOK OF MEDICINE

A new and distinguished team of Editors guides this well-known textbook in its *New (11th) Edition*. Its basic philosophy is to provide precise and thorough descriptions of those disease entities you are likely to encounter. Each is discussed fully and completely: *etiology, epidemiology; morbid anatomy; pathologic physiology; symptoms; diagnosis; prognosis; therapy*. Contents range from a commentary on *Patient-Physician Communication* to *Management of Bronchopulmonary Insufficiency*. In this revision you'll find increased emphasis on pathologic physiology; a new section on *Genetic Disease;* expansion of the material on *Viral Diseases;* reorganization and augmentation of sections on *Bronchopulmonary Disease* and *Gastroenterology;* a brilliant discussion of *Nucleic Acids, Genes, Viruses, and Immunity;* 67 new contributors. *The text is available either as a single volume or a two-volume set.*

Edited by PAUL B. BEESON, M.D., Ensign Professor of Medicine, Yale University School of Medicine; and WALSH MCDERMOTT, M.D., Livingston Farrand Professor of Public Health, Cornell University Medical College. With contributions by 173 authorities. With the assistance of 5 Associate Editors. About 1822 pages, 7⅜" x 10¾", with about 238 illustrations. Single Volume About $19.50. Two-Volume set About $23.50.

New (11th) Edition—Ready June!

New (2nd) Edition!
Aegerter and Kirkpatrick—
ORTHOPEDIC DISEASES

Dr. Aegerter, a pathologist, and Dr. Kirkpatrick, a radiologist, examine bone disease from the standpoint of its altered morphology and physiology—and then interpret the alterations in terms of symptomatology and roentgenology. For each skeletal disease (ranging from *Achondroplasia* to *Villonodular Pigmented Synovitis)* the authors describe: clinical manifestations: radiographic and laboratory findings; prognosis. For this up-to-date *New (2nd) Edition* there is considerably more material on radiographic demonstration of bone lesions and much greater emphasis on bone diseases and lesions of children. There are few other sources in which all the basic aspects of bone and joint disease are so well illuminated. Its conciseness is such that the general practitioner can gain a better understanding of the complex aspects of arthritis and bone diseases without sifting masses of material.

By ERNEST AEGERTER, M.D., Professor of Pathology and Director of the Department of Pathology, Temple University Medical Center and School of Medicine; Professor of Orthopedic Pathology, University of Pennsylvania Graduate School of Medicine; Chief in Pathology, Philadelphia General Hospital; and JOHN A. KIRKPATRICK, Jr., M.D., Radiologist, St. Christopher's Hospital for Children; Associate Professor of Radiology (Pediatrics), Temple University School of Medicine; Radiologist, Children's Heart Hospital. About 800 pages, 6½" x 9¾", with about 541 illustrations. About $16.00.

New (2nd) Edition—Ready June!

New (5th) Edition!
Andrews and Domonkos—
DISEASES OF THE SKIN

You'll find a concise, practical approach to clinical recognition and therapy of skin diseases in this *New (5th) Edition*—soundly based on modern histopathology. Virtually every dermatologic disease commonly encountered in practice is discussed—*eczema, hives, acne, impetigo, athlete's foot, pruritis, cutaneous neurosis,* etc. Anatomy, physiology, etiology and pathology of the skin and its disorders are meticulously discussed. Indications for surgical treatment are pointed out and techniques for biopsy and electrosurgery are fully described. A major feature of the *New (5th) Edition* is the inclusion of 175 new, brilliantly clear photographs of skin lesions to aid you in recognition. Many significant new entities have been added. All of the chapters are completely revised. The uses and possible hazards of newer drugs such as *amphotericin B, Norethynodrel, corticosteroids, micronized griseofulvin,* are described. There is full coverage of the connective tissue (Collagen) diseases and a description of newly recognized diseases of the reticuloendothelial system.

By GEORGE C. ANDREWS, M.D., Clinical Professor of Dermatology (Ret.) and ANTHONY DOMONKOS, M.S., Assistant Clinical Professor of Dermatology, College of Physicians and Surgeons, Columbia University. About 752 pages, 7" x 10", with about 596 illustrations. About $18.00.

New (5th) Edition—Ready June!

To Order Mail Coupon Below!

W. B. SAUNDERS COMPANY
West Washington Square Philadelphia 5

Please send and bill me:

☐ Beeson & McDermott—
Cecil-Loeb *Textbook of Medicine*....About $19.50
☐ 2 vol. set.....About $23.50

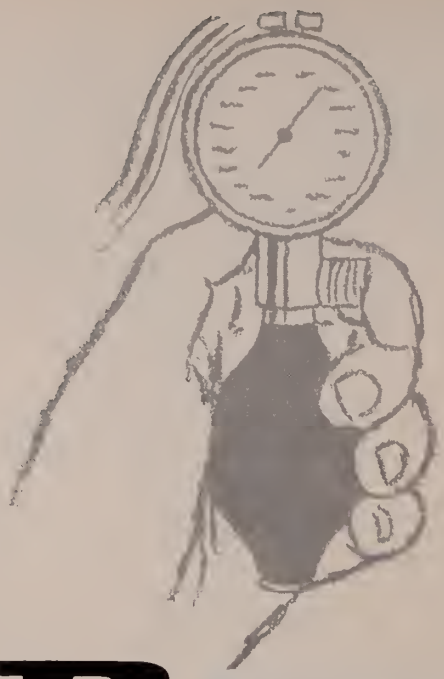
☐ Andrews & Domonkos—
Diseases of the Skin.....About $18.00

☐ Aegerter & Kirkpatrick—
Orthopedic Diseases.....About $16.00

Name.....

Address.....

SJG 6-63



when the pressure is up...

Rauprote

(RAUWOLFIA SERPENTINA AND PROTOVERATRINES A & B COMBINED)

Rauprote is a combination of proved antihypertensive agents. Rauwolfia Serpentina provides a moderately tranquilizing and hypotensive effect. Protoveratrines A and B bring a quicker, more potent lowering of blood pressure and bradycrotic action. The combination of agents produces a therapeutic effect superior to even large doses of either drug alone, and reduced dosages of both components in Rauprote minimize toxic side effects.[1,2] Rauprote therapy has been shown[2] to induce excellent responses from the majority of patients suffering from mild to moderately severe levels of blood pressure.

REFERENCES: 1. Goodman, L.S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., Macmillan & Co., New York, 1955. 2. Roberts, E.: Four Year Evaluation of an Antihypertensive Agent, J.A.M. Women's Assn. *13*:349, 1958.

FORMULA
Each tablet contains 50 mg. Rauwolfia Serpentina and 0.2 mg. Protoveratrines A and B (alkaloids of *Veratrum Album*).

INDICATION
Management of moderate to severe hypertension.

SIDE EFFECTS
Usually mild and may include nausea, nasal stuffiness, occasional drowsiness and loose stools.

CONTRAINDICATIONS
Mental depression, ulcerative colitis, peptic ulcer. Use with caution in gravid patients.

SUPPLIED
Bottles of 100 and 1000 tablets.

VALE

THE VALE CHEMICAL COMPANY, INC.
ALLENTOWN, PENNSYLVANIA

Abscess
Acne
Amebiasis, acute, intestinal
Anthrax
Bacillary dysentery
Bacteremia
Bartonellosis
Bronchitis, acute
Bronchopulmonary infection
Brucellosis, acute
(IN COMBINATION WITH OTHER ANTIMICROBIAL AGENTS)
Chancroid
Diphtheria
(IN CONJUNCTION WITH ANTITOXIN AND ROUTINE ESTABLISHED THERAPY)
Endocarditis, subacute, bacterial
Genitourinary infection
Gonorrhea
Granuloma inguinale (DONOVANOSIS)
Infections associated with pancreatic fibrosis
Listeriosis
Lymphogranuloma venereum
Meningitis, purulent
Mixed bacterial infection
Osteomyelitis
Otitis
(EXTERNA OR MEDIA)
Pertussis
Pharyngitis
Pneumonia
(WITH OR WITHOUT BACTEREMIA)
Psittacosis
Pyelonephritis, acute and chronic
Rocky Mountain spotted fever
Scarlet fever

proven effective in over

50

disease entities...

Septicemias
(STAPHYLOCOCCAL AND PNEUMOCOCCAL)
Sinusitis
Soft tissue infections
Tonsillitis
Tularemia
Typhus fever
Urethritis
(NONGONOCOCCAL)
associated with tetracycline-sensitive microorganisms, the more important of which are:
STREPTOCOCCI
STAPHYLOCOCCI
PNEUMOCOCCI
GONOCOCCI
SHIGELLAE
RICKETTSIAE
KLEBSIELLAE
and, in particular, with certain species of tetracycline-sensitive microorganisms such as the following:
HEMOPHILUS INFLUENZAE
STREPTOCOCCUS PYOGENES
DIPLOCOCCUS PNEUMONIAE
CORYNEBACTERIUM DIPHTHERIAE
ESCHERICHIA COLI
Surgical and dental preoperative and postoperative prophylaxis
Syphilis
(WHERE THE PATIENT IS PENICILLIN-SENSITIVE)
Typhoid fever
(WHEN CHLORAMPHENICOL IS CONTRAINDICATED)
Agammaglobulinemia or hypogammaglobulinemia and recurring infections
(WITH GAMMA GLOBULIN THERAPY)

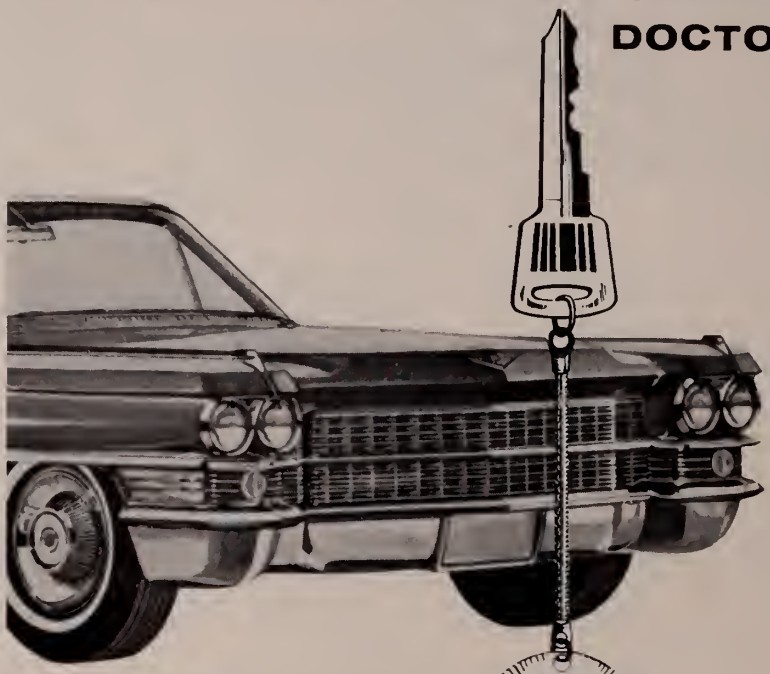
ACHROMYCIN® V

TETRACYCLINE HCl WITH CITRIC ACID

SIDE EFFECTS (infrequent and usually mild): glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. CONTRAINDICATIONS: None, but the following precautions should be observed: high-calcium-content foods or drugs should not be taken for at least one-half hour after each dose; avoid excessive accumulation of antibiotics by reducing dosage in patients with impaired renal function; consider possibility of discoloration of teeth during tooth development (late pregnancy, infancy or early childhood).
CAPSULES—250 mg. and 100 mg.; SYRUP; PEDIATRIC DROPS.

Lederle LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York
6421-3

KEYED to your profession, DOCTOR.....



COASTAL

CAR LEASING GETS YOU THERE!

SELECT THE CAR YOU WANT ■ ANY MAKE, ■ ANY MODEL ■ NO INVESTMENT ■ NO FINANCE CHARGES ■ 100% TAX DEDUCTIBLE EXPENSE ■ ONE FIXED MONTHLY COST INCLUDES MAINTENANCE, REPAIRS, INSURANCE, TIRES, REGISTRATION ■ IMMEDIATE REPLACEMENT

TAILOR-MADE PLANS FOR THE MEDICAL PROFESSION····WRITE OR CALL

COASTAL CAR LEASING

DIVISION OF COASTAL MOTOR LINES

23 JOHN STREET, EAST RUTHERFORD, NEW JERSEY — GE 8-0790

Get your low-back patient back to work in days instead of weeks



You can expect rapid results from 'Soma' (carisoprodol)—because this unique drug breaks up both the spasm and pain of low-back syndrome at the same time.

Your patients will usually begin to feel better within a few hours. And as Kestler demonstrated in a controlled study of 212 consecutive patients with low-back problems: the average time for full recovery was only 11.5 days with 'Soma' (carisoprodol), 41 days without it. (J.A.M.A., April, 1960.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely.

USUAL DOSAGE: ONE 350 MG. TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

Soma®
carisoprodol

Wallace Laboratories
Cranbury, New Jersey

PROFESSIONAL LIABILITY INSURANCE PROGRAM

officially endorsed by

THE MEDICAL SOCIETY OF NEW JERSEY

PROTECTION for Professional Acts and Professional Premises Liability for members of The Medical Society of New Jersey by the First American Liability Insurance Company.

LOSS CONTROL. Your County Medical Review and Advisory Committee will evaluate malpractice cases and recommend the action which would be most favorable for the Medical Profession, the Defendant Doctor, the Patient and the Public. This program permits understanding of the complex problems involved in such cases and calls for close cooperation between the Medical Profession and Insurance Company.

MEDICO-LEGAL FORMS are furnished to each insured doctor to help in reducing claims or dissatisfied patients. Failure to use forms does not affect the doctor's insurance coverage or his eligibility for insurance.

INSURANCE COUNSELING. Insurance counseling and advice, available at all times, without cost, to help you with your Professional Liability insurance problems.

CANCELLATION. No policy will be cancelled or non-renewed without prior consultation between your Society and the Company and this is a matter of complete cooperation for the best interests of all concerned.

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY

Policies Guaranteed Non-assessable

Professional Liability Department

123 CLEVELAND STREET — ORANGE, NEW JERSEY

Joseph A. Britton, Manager — ORange 3-2575

Home Office: Wakefield, Mass.



after surgery: vitamins are therapy

Nutritional supplementation is basic to postoperative care. Therapeutic allowances of B and C vitamins help meet increased metabolic requirements and compensate for stress depletion. STRESSCAPS can set the patient on a more favorable course and contribute to full recovery.

FOR PROFESSIONAL

RECOMMENDATION ONLY

Each capsule contains: Vitamin B_1 (Thiamine Mononitrate)...10 mg. / Vitamin B_2 (Riboflavin)...10 mg. / Niacinamide...100 mg. / Vitamin C (Ascorbic Acid)...300 mg. / Vitamin B_6 (Pyridoxine HCl)...2 mg. / Vitamin B_{12} Crystalline...4 mcgm. / Calcium Pantothenate...20 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

6316-3

STRESSCAPS®

Stress Formula Vitamins Lederle



Relieves Anxiety and Anxious Depression

The outstanding effectiveness and record of safety with which 'Miltown' (meprobamate) relieves anxiety and anxious depression has been clinically authenticated time and again during the past eight years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more than any other tranquilizer in the world.

Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

Usual dosage: 1 or 2 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50.

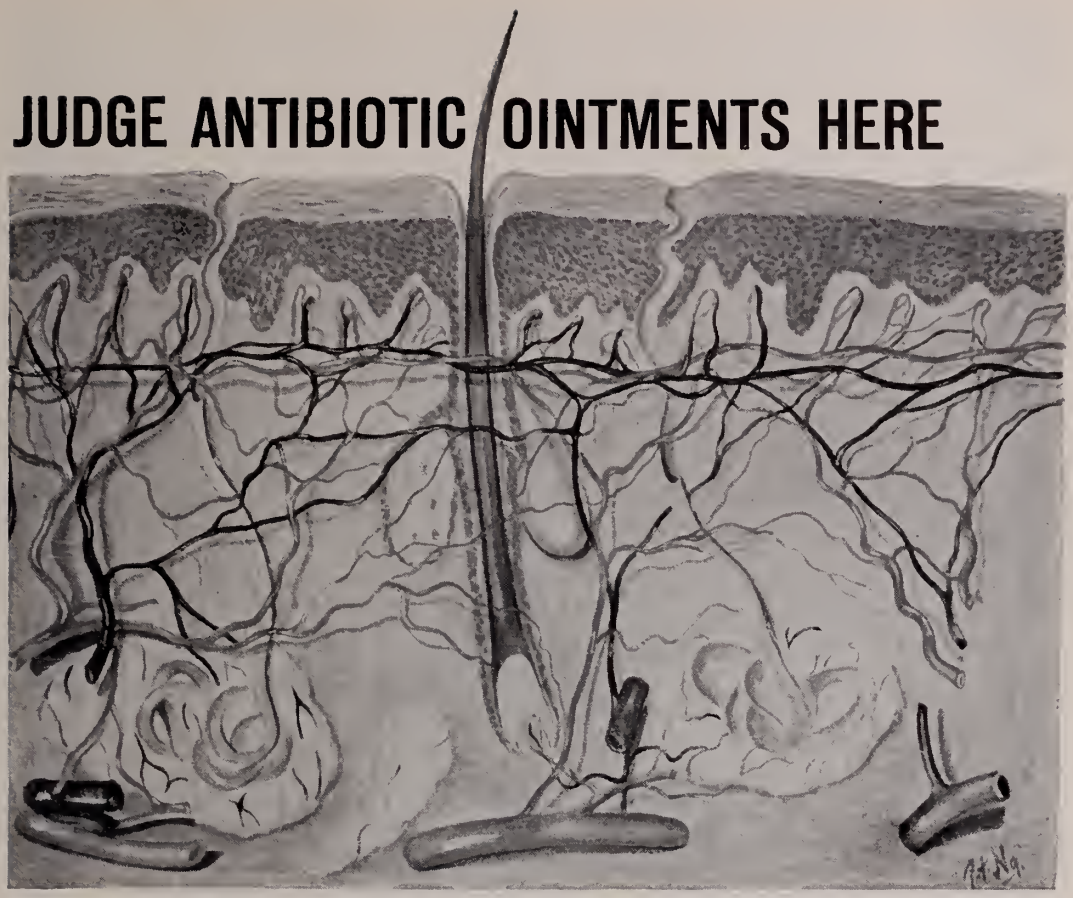
the original meprobamate

Miltown®

WALLACE LABORATORIES / *Cranbury, N.J.*

CM-924

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Antibiotic Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and rarely sensitizes.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

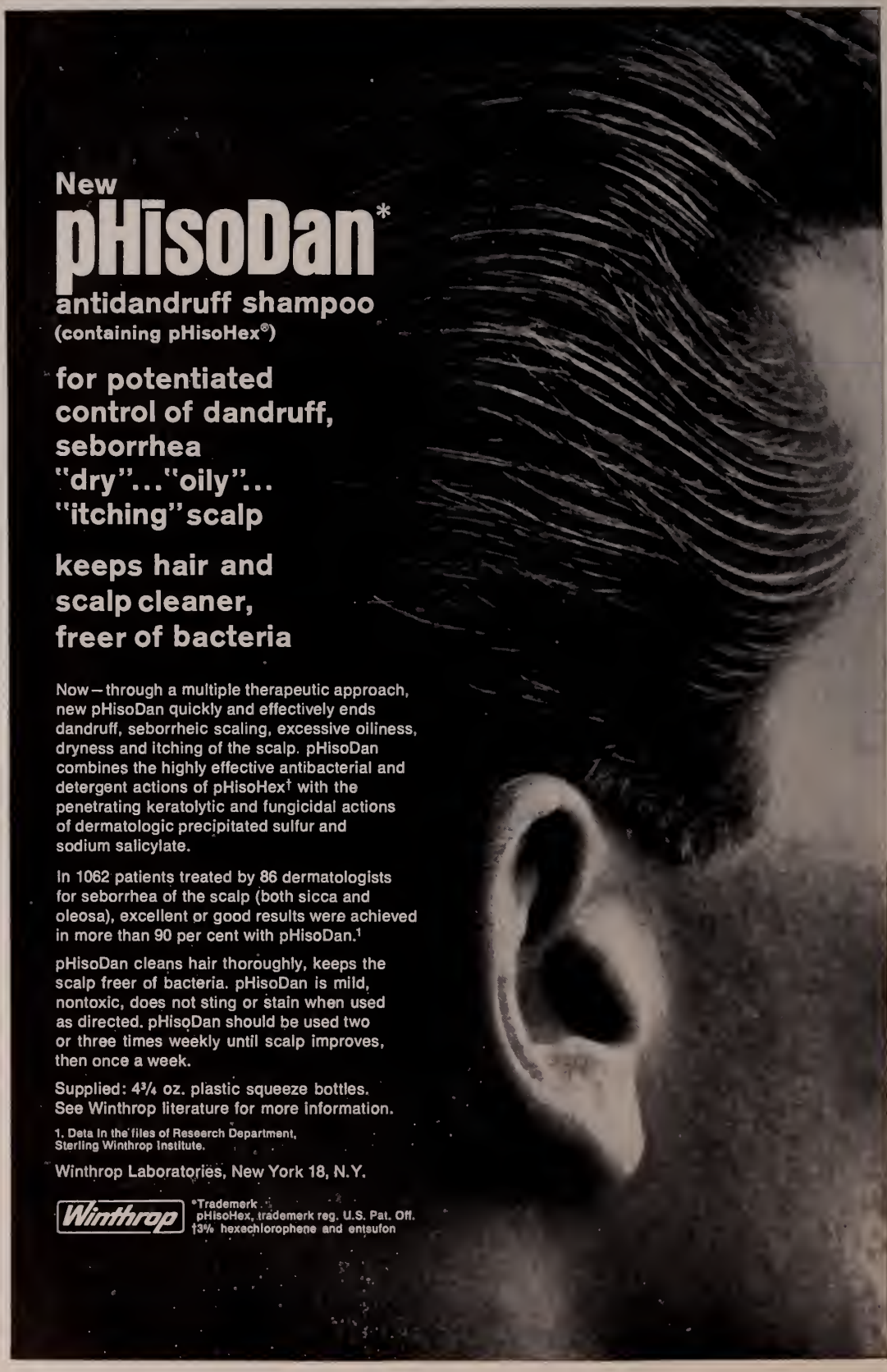
Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN ANTIBIOTIC OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.


New
pHisoDan*
antidandruff shampoo
(containing pHisoHex®)
for potentiated control of dandruff, seborrhea "dry"..."oily"... "itching" scalp
keeps hair and scalp cleaner, freer of bacteria
Now—through a multiple therapeutic approach, new pHisoDan quickly and effectively ends dandruff, seborrheic scaling, excessive oiliness, dryness and itching of the scalp. pHisoDan combines the highly effective antibacterial and detergent actions of pHisoHex† with the penetrating keratolytic and fungicidal actions of dermatologic precipitated sulfur and sodium salicylate.
In 1062 patients treated by 86 dermatologists for seborrhea of the scalp (both sicca and oleosa), excellent or good results were achieved in more than 90 per cent with pHisoDan.1
pHisoDan cleans hair thoroughly, keeps the scalp freer of bacteria. pHisoDan is mild, nontoxic, does not sting or stain when used as directed. pHisoDan should be used two or three times weekly until scalp improves, then once a week.
Supplied: 4¾ oz. plastic squeeze bottles.
See Winthrop literature for more information.
1. Data in the files of Research Department, Sterling Winthrop Institute.
Winthrop Laboratories, New York 18, N.Y.
Winthrop
*Trademerk
pHisoHex, trademerk reg. U.S. Pat. Off.
†3% hexachlorophene and entsufon

Solfoton®

for mild, continuous sedation

Each tablet (or capsule) contains 16 mg. phenobarbital blended with 65 mg. Bensulfoid®. The Bensulfoid is an inert diluent present to permit slow absorption of the phenobarbital. The usual dosage is one tablet or capsule after meals and at bedtime. Solfoton is especially adapted to prolonged use because of its virtual freedom from depression and other side effects. Contra-indications: identical to those of ¼ gr. phenobarbital.

REFER TO PDR

Poythress, White Section, Page 808 (1963 edition) and Product Identification Section

COMPLETE INFORMATION AND CLINICAL SAMPLES SENT UPON REQUEST

Dispensed in bottles of 100 and 500 tablets or capsules

WM. P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856



Deltasmyl®

Theophylline (120 mg.)
Ephedrine HCl (15 mg.)
Phenobarbital (8 mg.)
(Barbituric acid derivative)
Prednisone (1.5 mg.)

for safer steroid protection from asthma

DELTASMYL® opens the airways and suppresses inflammation by combining the anti-allergic, anti-inflammatory action of prednisone with the bronchodilating, decongestant and quieting effects of theophylline, ephedrine and phenobarbital.

DELTASMYL provides prompt, prolonged relief of asthma with prednisone protection against allergens and stress, and a wider margin of safety through reduction of the effective corticoid dose.

The aim of therapy in asthma should be relief of bronchospasm by means of decongestant and bronchodilating agents—plus prednisone, not just prednisone alone.[1] Uhde[2]—using theophylline-ephedrine-phenobarbital with prednisone—reports an increase of about 25% in the action of prednisone with quicker arrest of inflammation, hypersecretion, and alveolar stasis; a marked sedative action on heart and circulation; improved ventilation. Bopp[3] also has obtained satisfactory results with the same combination, probably through synergistic enhancement of prednisone potency.

Dosage: One DELTASMYL tablet provides symptomatic relief for 4 hours or longer. Not more than 6 tablets should be taken in 24 hours. Withdraw gradually.

Precautions: DELTASMYL contains ephedrine and should not be given with epinephrine since both drugs may cause tachycardia. Carefully observe patients hypersensitive to sympathomimetic amines. Phenobarbital is a barbituric acid derivative which may be habit forming. Despite the low prednisone dose, all precautions and contraindications of corticosteroids must be heeded, since warning signs such as fluid retention or moon face may not be present. When corticosteroids are given to patients with acute or chronic bacterial infections, appropriate protection should be provided.

Contraindications: Hyperthyroidism, cardiovascular diseases, peptic ulcer, diabetes mellitus, psychotic tendencies, ocular herpes simplex, glaucoma, prostatic hypertrophy, Cushing's syndrome, arrested tuberculosis.

Supplied: Bottles of 50 tablets, on prescription only.

References: 1. Barach, A. L. and Bickerman, H. A.: Pulmonary Emphysema, Baltimore, Williams & Wilkins, 1956, p. 523. 2. Uhde, H.: Med. Monatsschr. No. 8, 505, 1959. 3. Bopp, K. Ph.: Medizinische Klinik 53:186, 1958 and Algerie Medicale 62:1081, 1958.

ROUSSEL

Roussel Corporation

155 East 44th Street, New York 17, N.Y.

throughout the wide middle range of pain — control with one analgesic PERCODAN® tablets

(Salts of Dihydrohydroxycodeinone and Homatropine, plus APC)

In a comprehensive range of indications marked by moderate to moderately severe pain, PERCODAN assures speed, duration, and depth of analgesia by the oral route... acts within 5 to 15 minutes... usually provides uninterrupted relief for 6 hours or longer with just 1 tablet... rarely causes constipation.



Formula — Each scored yellow PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone HCl (Warning: May be habit-forming), 0.38 dihydrohydroxycodeinone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. acetophenetidin, and 32 mg. caffeine. Also available: PERCODAN®-DEMI, containing the complete PERCODAN formula but with only half the amount of salts of dihydrohydroxycodeinone and homatropine. Both products are on oral Rx in all states where laws permit. **Average Adult Dose**—1 tablet every 6 hours. **Side Effects and Contraindications**—Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to acetylsalicylic acid or acetophenetidin and in those with blood dyscrasias. *Literature on request.* **ENDO LABORATORIES Richmond Hill 18, New York**

Endo®

*U.S. Pats. 2,628,185 and 2,907,768

BLUE SHIELD



A CHALLENGE!

To each of its 6,700 Participating Physicians in New Jersey, Blue Shield presents a challenge to back up sound conviction with practical, effective support.

The Conviction: that a program of medical care prepayment by voluntary effort is good for the profession and good for the country.

Effective Support: become well informed about the Blue Shield program, its problems, its objectives and its specific policies. Once informed, speak at every opportunity about the tremendous social asset that Blue Shield represents. And perhaps most important of all, make certain that each subscriber receives the full benefits for which he has contracted. In this way the public will come to know Blue Shield as a symbol of protection against economic catastrophe and an assurance of the highest quality of medical care in the true American tradition.

And the one New Jersey physician in five who has not yet joined Blue Shield can help to meet today's challenge — by participation.

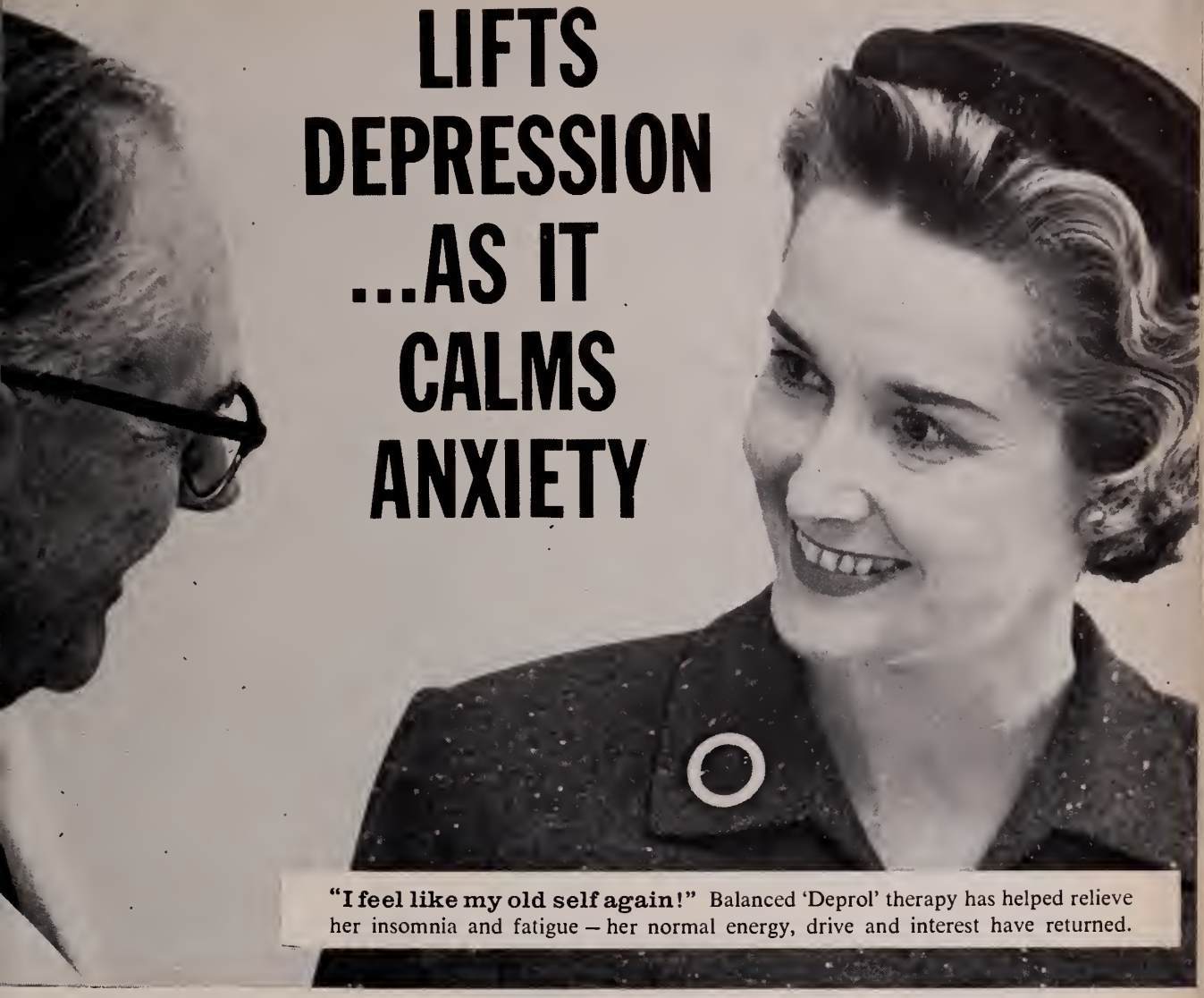


BLUE SHIELD®

Medical-Surgical Plan of New Jersey

500 Broad Street, Newark

LIFTS DEPRESSION ...AS IT CALMS ANXIETY



"I feel like my old self again!" Balanced 'Deprol' therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

Brightens mood...relaxes tension

Energizers may stimulate the depressed patient, but they often aggravate anxiety and insomnia. Tranquilizers may help the anxious patient, but they often deepen depression. 'Deprol' avoids these "seesaw" effects; it relieves both anxiety and depression. Moreover, it does not cause liver damage, psychotic reactions or changes in sexual function.

Slight drowsiness and, rarely, allergic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

Usual Dosage: 1 tablet q.i.d. May be increased gradually, as needed, to 3 tablets q.i.d.; with establishment of relief, may be reduced gradually to maintenance levels.

▲Deprol▲®

meprobamate 400 mg. + benactyzine 1 mg.

WALLACE LABORATORIES / *Cranbury, N.J.*

Codeine at the White House Conference
Relative Safety Established

The just-published proceedings of the White House Conference on Narcotic and Drug Abuse include valuable information on the relative safety of codeine. An important contribution to this Conference was the "Report of an Ad Hoc Panel on Drug Abuse," drafted by eight prominent scientists and health officials. This report has been endorsed also by the Committee on Drug Addiction and Narcotics, National Research Council.

Among the points presented:

1. **Addiction to codeine is unusual***
2. **Substitution of codeine for another opiate to maintain addiction is rare**
3. **The very low abuse potential of codeine is recognized throughout the world**

This new report is an important addition to the vast body of clinical knowledge and literature on codeine. It is further evidence that the many codeine products available today may be prescribed and recommended with confidence.

Codeine has steadily maintained its status as a therapeutic agent of choice. It is still unique, being at once . . . relatively safe . . . orally and parenterally effective . . . versatile and widely compatible.

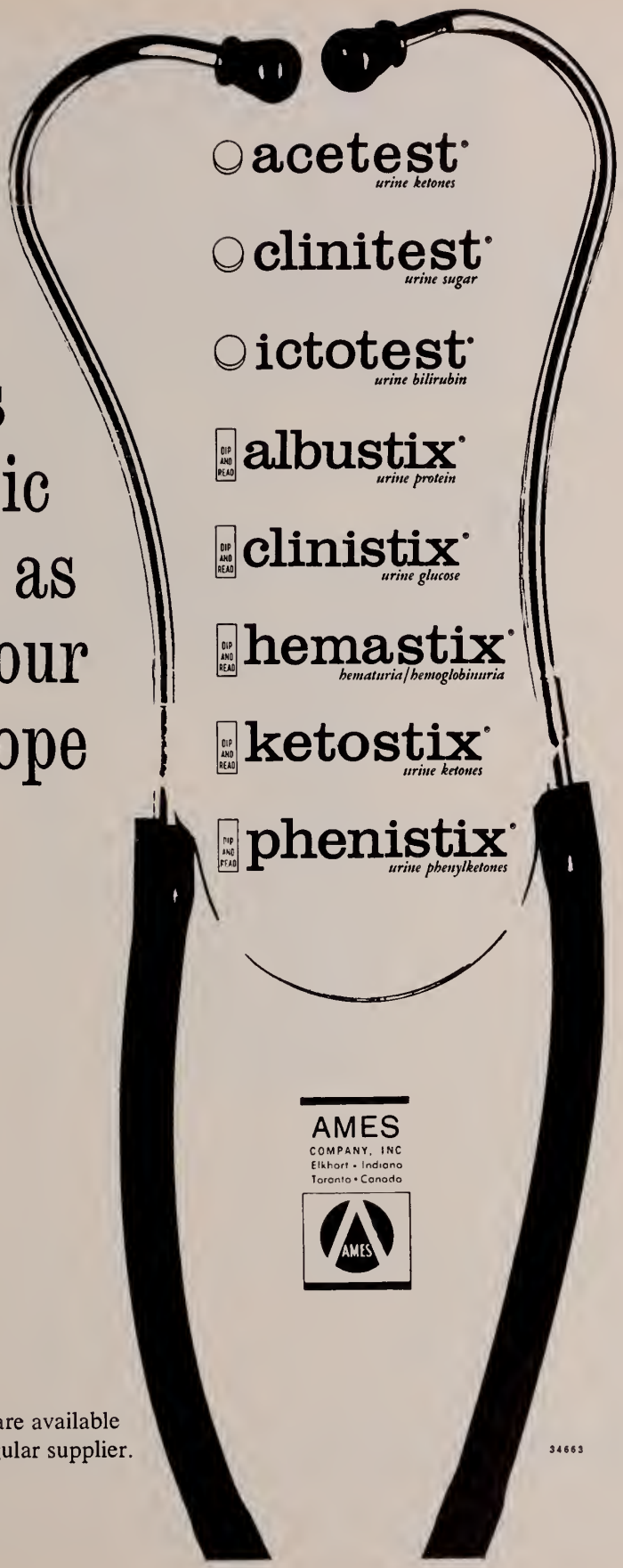
*Note also this statement by the former U.S. Commissioner of Narcotics, Hon. Harry J. Anslinger, given to the California Senate Judiciary Committee, March 27, 1963: "In my experience of 30 years, I have seen only one codeine addict."



MERCK

MERCK CHEMICAL DIVISION • MERCK & CO., INC. · RAHWAY, NEW JERSEY

urine tests as basic as your stethoscope



- acetest® — *urine ketones*
- clinitest® — *urine sugar*
- ictotest® — *urine bilirubin*
- DIP AND READ albustix® — *urine protein*
- DIP AND READ clinistix® — *urine glucose*
- DIP AND READ hemastix® — *hematuria/hemoglobinuria*
- DIP AND READ ketostix® — *urine ketones*
- DIP AND READ phenistix® — *urine phenylketones*

AMES
COMPANY, INC
Elkhart • Indiana
Toronto • Canada

AMES products are available through your regular supplier.

34663

"Doctor... I'm so tired all the time"



Lethargic patients respond to Ritalin

(methylphenidate hydrochloride)

When lethargy is a medical problem—in convalescence, chronic fatigue, mild depression, menopause, oversedation, and senility, for example—the gentle stimulant action of Ritalin (methylphenidate hydrochloride) restores normal physical and mental activity.

In his report, Siegler[1] states: "In mild depression or in clinical exhaustion syndromes, a marginal sympathomimetic drug like methylphenidate seems to be the drug of choice for initiating therapy. It does not have the toxic effects found with the amphetamines or with the hydrazines or other antidepressants."

Other significant comments on the clinical safety of Ritalin (methylphenidate hydrochloride): "At no time was there evidence of serious toxic reactions [in a study of 185 patients]. The drug did not produce alteration in blood forming factors, kidney and liver function."[2]

"No significant toxic effects have resulted after the continuous administration of methylphenidate for more than 3 years."[3]

INDICATIONS: Chronic fatigue.

CONTRAINDICATIONS: Marked anxiety, tension, and agitation.

CAUTION: Should not be used to increase mental or physical capacities beyond normal limits. Use cautiously with epinephrine or levarterenol.

SIDE EFFECTS: Nervousness, insomnia, anorexia, nausea, dizziness, palpitations, headache, drowsiness.

DOSAGE: 10 to 20 mg. b.i.d. or t.i.d.

SUPPLIED: *Tablets*, 5 mg. (pale yellow), 10 mg. (pale blue) and 20 mg. (pale orange).

REFERENCES: 1. Siegler, P. E., in Nodine, J. H., and Moyer, J. H. (Editors): *Psychosomatic Medicine*, The First Hahnemann Symposium, Lea & Febiger, Philadelphia, 1962, p. 582. 2. Lapolla, A.: Western Med. *2*:383 (Sept.) 1961. 3. Yoss, R. E., and Daly, D. D.: Pediatrics *25*:1025 (June) 1960.

2/3098MB

CIBA SUMMIT, N. J.

Ritalin® hydrochloride (methylphenidate hydrochloride CIBA)

most effective in the obese diabetic...

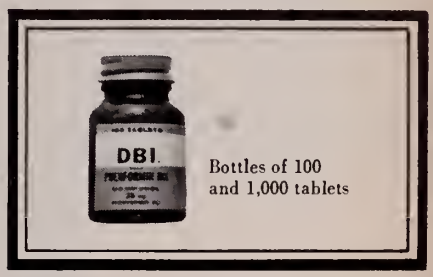
ecent reports suggest... sulin and sulfonylureas ay accelerate lipogen- sis, fat accumulation, eight gain; thus appear aggravate obesity in di- betics[1-5]...serum "insulin" vels are often elevated obese diabetics[2,3,6]...DBI henformin HCl) reduces gh blood sugars, lowers evated "insulin" levels, ends to reduce body eight toward normal.[1,3,7-9]

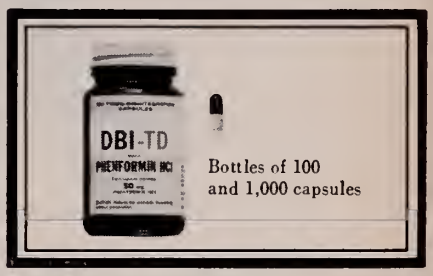
BI and DBI-TD (phenformin Cl), administered to ketoacidosis- sistant diabetics requiring hypogly- mic therapy: **A.** act to reduce high ood sugar without increasing fat nthesis or weight gain as insulin and sulfonylureas tend to do. **B.** do not increase already elevated endogenous insulin levels; may, indeed, act to restore more normal insulin levels. **C.** favor reduction of weight towards normal.

Insulin is still the essential hypoglycemic agent for the ketoacidosis-prone diabetic. However, in the ketoacidosis-resistant obese diabetic phenformin appears to be the hypoglycemic of choice to help avoid weight gain or reduce adiposity, a factor tending to make control more difficult and to increase the likelihood of complications.



Summary: Indicated in stable adult diabetes, sulfonylurea failures and unstable diabetes. Gastrointestinal side effects occurring more often at higher dosage levels abate promptly upon dosage reduction or temporary withdrawal. Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis, and treated accordingly. Use with caution in severe liver disease. Not recommended without insulin in acute complications (acidosis, coma, infections, gangrene, surgery). See product brochure for full information.





Bibliography: 1. Williams, R. H.: Textbook of Endocrinology, Ed. 3, Saunders, Philadelphia, 1962, p. 610. 2. Gordon, E. S.: Metabolism 11:819, 1962. 3. Grodsky, G. M. et al.: Metabolism 12:278, 1963. 4. Sadow, H. S.: Metabolism 12:333, 1963. 5. West, K. M. and Tophoj, E.: Metabolism 10:689, 1961. 6. Yalow, R. S. and Berson, S. A.: Diabetes 9:254, 1960. 7. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 8. Weller, C. et al.: Metabolism 11:1134, 1962. 9. Radding, R. S. et al.: Metabolism 11:404, 1962.

tablets 25 mg. **DBI®**

timed-disintegration capsules 50 mg. **DBI-TD®**

BRAND OF PHENFORMIN HCl

U. S. VITAMIN & PHARMACEUTICAL CORP. 800 SECOND AVE. NEW YORK 17, N.Y.

Webcor Music Man

STEREOPHONIC HIGH FIDELITY TAPE RECORDER

...the ultimate in tape recorder performance!



PPICED AT only $198.80

- 2 and 4 track stereo operation
- 3 speeds—1⅞, 3¾, and 7½ ips.
- New, simplified "push-lever" operation
- Self-contained stereo record and playback
- Digital tape counter with pushbutton reset
- Dual volume controls—one for each channel
- Dual bass and treble controls

If you're the "one in a hundred" with a highly critical ear for perfection in sound, you'll be satisfied with nothing less than the new Webcor "MUSIC MAN" stereo tape recorder. And it's ever so simple to operate! Just push the lever up to "Play"... push it down to "Stop"... move it to the left to "Rewind"... to the right for "Fast Forward." Treat yourself to a thrilling new hearing experience. Ask for a demonstration today at—

Write for catalog to Exclusive N. J. Wholesale Distributors

ALL-STATE DISTRIBUTORS

INCORPORATED

457 CHANCELLOR AVE. NEWARK, N. J.

WAverly 3-4900

Question:

"What is a tranquilaxant?"

Answer:

"A drug that is both a tranquilizer and a muscle relaxant."

TRANCOPAL®
brand of
chlormezanone
is a tranquilaxant

As a tranquilizer, TRANCOPAL (chlormezanone/Winthrop) "is effective in the symptomatic treatment of anxiety."[1] Its tranquilizing properties are similar to those of other mild tranquilizers.[1] Furthermore, it relieves tension of both mind and muscle without interfering with normal activity or alertness.

The muscle relaxant properties[2] of this drug provide an extra dimension of effectiveness...relaxing the spasm which so frequently accompanies psychogenic disorders. Hence, the total therapeutic effect of TRANCOPAL (chlormezanone/Winthrop)—a true "tranquilaxant"—is to produce a relaxed mind in a relaxed body.

Unsurpassed Tolerance: Less than 3 per cent of patients develop side effects with TRANCOPAL (chlormezanone/Winthrop), such as occasional drowsiness, dizziness, flushing, nausea, depression, weakness and drug rash. If severe, medication should be discontinued. In most patients, however, side effects are minor and do not necessitate interruption of treatment. There are no known contraindications.

Available: 200 mg. Caplets® (green colored, scored), 100 mg. Caplets (peach colored, scored), each in bottles of 100.

Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; in some patients 100 mg. three or four times daily suffices. Children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Winthrop
WINTHROP LABORATORIES
New York 18, N.Y.

References: 1. A.M.A. Council on Drugs: J.A.M.A. 183:469 (Feb. 9) 1963. 2. Gruenberg, F.: Curr. Ther. Res. 2:1 (Jan.) 1960.

Flavoring Improves Palatability of Acidophilus Milk

In the treatment of acne vulgaris and such gastro-intestinal disorders as simple chronic constipation and simple diarrhea, patient resistance to ingestion of Acidophilus may be controlled if flavor is improved by stirring 1 to 2 teaspoons of Jell-O powder into each glass of Acidophilus Milk before serving. Most popular flavors are raspberry, cherry, orange-pineapple, blackberry, and strawberry. For patients on low-calorie diets, substitute D-Zerta for Jell-O. Add a few drops of Sweeta or Sweet-10 to the flavored Acidophilus for a sweeter drink.

WALKER-GORDON ACIDOPHILUS

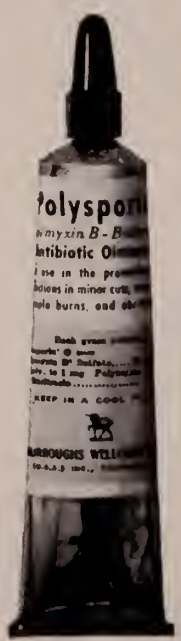
2% butterfat, made from Walker-Gordon Certified Milk cultured with 300-500 million acidophilus bacilli per ml. Available through leading milk dealers.

WALKER-GORDON CERTIFIED MILK FARM, Plainsboro, N. J.

SWinburne 9-1234 (N. Y. WAlker 5-7300; Phila. PEnnypacker 5-3465)

---

in treating topical infections, no need to sensitize the patient



USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN ANTIBIOTIC OINTMENT

broad-spectrum antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **Supplied:** in ½ oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain...not the patient").*

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

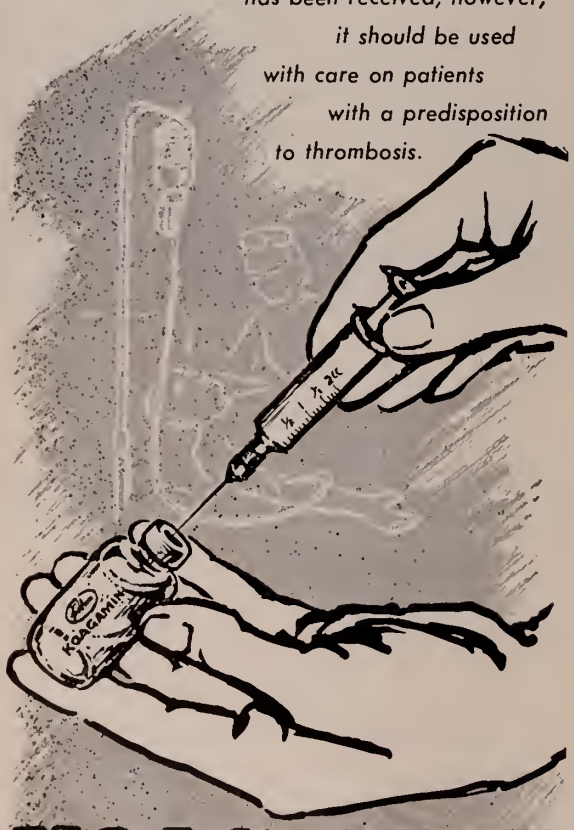
carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

®WALLACE LABORATORIES / *Cranbury, N.J.*

CSO-9193

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem. KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.



KOAGAMIN®

parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenal 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

CHATHAM PHARMACEUTICALS, INC.
Newark 2, New Jersey
Distributed in Canada by Austin Laboratories, Ltd. • Paris, Ontario

Digitalis

in its completeness



Each pill is
equivalent to
one USP Digitalis Unit

Physiologically Standardized
therefore always
dependable.

Clinical samples sent to physicians upon request.

Davies, Rose & Co., Ltd.
Boston, 18, Mass.

Schering

in dermatoses amenable to topical steroid therapy

METI-DERM®

Prednisolone, 16.6 mg. in 50 Gm. container and 50 mg. in 150 Gm. container; in nonsensitizing vehicle—isopropyl myristate with inert propellants—trichloromonofluoromethane, dichlorodifluoromethane.

AEROSOL COOLS

instant cooling, soothing effect • covers every part of the lesion, any area of involvement • controls the itch, delimits the area of edema and erythema • nonfluorinated—avoids risk of steroid absorption • easy to carry and apply away from home—no residue on the skin



Clinical Considerations: In allergic dermatoses, until the specific causative agent is identified and removed from the patient's environment, the condition may be expected to recur when therapy is terminated. If infection is present, appropriate antibacterial measures should be taken. METI-DERM (prednisolone) Aerosol should not be sprayed around the eyes. Contents of can are not flammable but are under pressure. Containers should be stored in a cool place and neither punctured nor incinerated. For complete details, consult Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey.

® prednisolone topical, Schering.

S-192R



This is half an inspection



. . . this is the other half



Inspecting a coated tablet poses a two-sided problem: How do you make certain that both top and bottom are flawless without picking up each tablet and turning it? ■ We have a machine especially designed to do the job. The tablets pass along a belt under the watchful eye of an inspector. Any tablet that has the slightest irregularity in shape or coating is rejected. Then a second belt overrides the first and, holding the tablets tightly in place, turns them over and delivers them to another belt for inspection of the other side. ■ It is another in a long series of control measures designed to deliver quality pharmaceuticals every time.

Eli Lilly and Company • Indianapolis 6, Indiana, U. S. A.

Lilly

390079

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Jerome G. Kaufman: Our New Leader



Leadership is one of those mysterious qualities, easy to recognize, hard to describe. Whatever it is, Jerome Kaufman has it. He finished his internship in 1927, but within a few years was being named as chairman of this and chairman of that. He went to medical school at Bellevue, and then became a faculty member at professorial level. He interned at Newark City Hospital, and then became a senior attending (now an emeritus) in medicine there. He served the Newark Beth Israel Hospital, too, and before long became president of their medical staff. He was a pioneer in working with cardiac children and became medical director of the UOTS Home for Cardiac Children. He joined the Essex County Medical Society in 1927, but didn't stay long in the back row. He became president of that society. He interested himself in the work of the New Jersey Heart Association, then became its president. He turned his talents to the American Heart Association and is now its vice-president. He was one of the early

Published Monthly Since 1904 — Henry A. Davidson, M.D., Editor
Under the Direction of the Committee on Publication — Theresa E. Goeke, Assistant Editor
George B. Sharbaugh, M.D., Chairman

Place of Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — EXport 4-3154
Each member of the Society is entitled to receive a copy of The Journal every month

Whole Number of Issues 706

Vol. 60, No. 6 — JUNE, 1963 — 50 Cents - $5.00 per year

practitioners to work with Chr-Ill Service and became president of that agency, too. The list is a long one, but the point is obvious. Whatever it takes to make a leader, you'll find it here.

In 1928, Dr. Kaufman married Maola Pross. Mrs. Kaufman has had an active civic and organizational career including a tour of duty as president of the Woman's Auxiliary to the Essex County Medical Society.

Dr. Kaufman is a native of Newark, who had his premedical education at Harvard. His M.D. came from Bellevue in 1925. After his internship at the Newark City Hospital, he did graduate work in cardiology and internal medicine. In the course of the next two decades he had become affiliated with, usually in a consultant capacity, some half a dozen hospitals in northern and central New Jersey. He was elected to Fellowship in the American College of Physicians and in 1940 was certified by the American Board of Internal Medicine. (That didn't take him long either: the Board wasn't established until 1936.)

His service to The Medical Society of New Jersey is so well known to most of our readers that it need not be repeated here. At a period when medicine has been under attack, it is comforting to have as our symbol, a doctor who so well merges clinical competence with time-tested and well demonstrated administrative and organizational leadership.

Introducting Pat Booth



An M.A. and a ma, a figure skater and a swimmer, a homemaker and an editor . . . all this and more, too. That's Pat Booth. And how she does it, nobody knows. Her B.A. comes from Dickinson College and her M.A. from Columbia University's Teacher's College. She has served the Woman's Auxiliary to the Union County Medical Society in almost every chairmanship and office there, from president down. Pat has been associated with such varied organizations as the Homemaker's Service, the Normandy Beach Yacht Club, the American Association of University Women and the Figure Skating Association. She started the *Newsletter* of the Union County Auxiliary. All this, in addition to chairing AMA-ERF, leading children's activities, doing scholarship committee work, fund raising, recruiting in health careers and rearing four children.

Auxiliary officers are usually doctors' wives. So, lest we forget—Pat is married to the director of obstetrics at St. Elizabeth's Hospital in Elizabeth: Dr. Walter S. Booth.

Is State Auxiliary leadership in good hands? What do you think?

JEROME G. KAUFMAN, M.D.

Maplewood

Measuring Up to Responsibility and Leadership*

Our leaders cannot do it alone: we individual members have serious responsibilities, too.

MORE and more in the course of the year just past and especially during the activities of this, the 197th annual meeting of our Society, I have come to appreciate that the office of President of The Medical Society of New Jersey—which by grace of your kindness I am now about to assume—is an assignment not only of great honor but of great responsibility.

For medicine, I think we may accurately say, these are at once the best of times and the worst of times. These are the best of times because never in the history of civilization have members of our profession been able to render so many saving and almost miraculous services to our fellowmen. These are the worst of times because, despite the extension of the life span and the improvement of the average general health of our citizens, never have physicians been under more widespread critical attack than now.

It is true, we are not criticized for our professional incompetence or inadequacy because, even to minds antagonistically disposed, the record of triumphant performance makes undeniably evident that physicians and surgeons today routinely achieve results that were not dreamed of in the proximate yesterdays.

Instead, we are blamed for not having been able, in the area of the cost of health services, to withstand the general inflationary trend of our national economy and to overcome the distressing effects of unsound habits of economic indiscipline which as a nation we have progressively indulged.

In consequence, today the men and women of medicine are called upon to engage in a two-fold warfare—the traditional and splendid offensive warfare against disease and death, and a bitter, new, defensive warfare against injustice and unreason.

We can neglect either warfare only at the risk of deadly peril—to the quality and standards of our professional services, if we neglect the one; and to the good name of our profession and to our dignity and freedom as individual American citizens, if we neglect the other. We *must not* neglect the one, and we *dare not* neglect the other.

Thus our task is heavy, but if we measure up to the challenges that face us and to the worth that is in us, we will prosecute both wars in a fashion "not unbecoming men who strove with gods."

In elevating me to the presidency of this ancient and distinguished Society, you call upon me to measure up to the demands of responsibility and leadership which the office imposes. In accepting that office, in turn I

*Inaugural Address, delivered at the annual meeting in Atlantic City, May 14, 1963, by Dr. Kaufman on the occasion of his installation as President of The Medical Society of New Jersey.

call upon you and all the members of our Society—and, indeed, of our profession—to measure up to the demands of responsibility and leadership which life in the United States today imposes upon us both as physicians and as citizens.

Responsibility and leadership are natural to a physician; they are the very warp and woof of the fabric of his life. No one unwilling to assume and acquit himself of extraordinary and weighty responsibilities, or indisposed to supply and exercise the powers of leadership, really belongs in the medical profession.

Each of us knows this from his own life and his own professional experiences. The boy who dreams of becoming a doctor must have in his soul a combination of compassion, aspiration, industry, and self-reliance that makes him akin to the giant-killers and the adventuresome knights of old.

The adversaries against whom he is determined to pit his strength and skill—most formidable adversaries, indeed—are Disease, Pestilence, and Death. His weapons are hard-won knowledge, precise and fearless judgment, disciplined professional skills, unflagging courage, patience, and perseverance.

To fit himself for the combat, to earn his status and prove his strength, with constant dedication the potential doctor must ceaselessly and tirelessly pursue an intellectual training program more ruthlessly exacting than that of any other professional field. He must prove himself in the lists—especially the endless, breath-stopping lists of examination results—until after decades of preparation and proving he wins the desired accolade and is permitted, alone and unaided, as the champion of life in his patients' behalf, to tilt with Death itself.

A doctor of medicine gladly spends the gold of his youth to achieve in his maturity those strengths of mind and heart that will enable him to assume responsibility for the welfare of his patients and to lead them out of the shadows of death into the sun of health and vigor again.

Yes, responsibility and leadership are natural to a physician; they are the very warp and woof of the fabric of his life.

The exactions of responsibility and leadership imposed upon the physician which thus far I have outlined almost exclusively arise out of his life as an individual member of the profession of Medicine. There are, however, other demands of responsibility and leadership which are his as a citizen, as a member of contemporary American society. And, in view of the hazards which everywhere abound and of the many critical decisions which as a people we are being called upon to make, the demands upon the physician as a citizen are as pressing and important—if not more so—than those which he must face up to as an individual physician.

In the traditional American system, the power of decision ultimately rests with the voters. As a people we know that the kind of government we get and the policies and principles under which we live and function are basically of our own choosing. In the United States, the good that is accomplished or the evil that ensues through decisions and operations of government at any level, in the final analysis must be attributed to the people themselves. "Who acts through an agent acts himself" is a familiar principle in law and in life. It is especially applicable in the area of government and statecraft. The people choose their leaders and representatives. By the exercise of their voting rights, the people retain the power of political life or death over those who thus serve them. If as a people we are to be wisely and well served, then as voters we must make wise and judicious choices of our public servants, and as constituents we must be prepared to give to our representatives the benefit and direction of our wise and judicious thinking.

Thus, under a system of government such as ours, the people possess the power to exalt or to destroy their country and themselves. We *have* the power as a people to get what we want, but the sad fact is that, because of the inadequacy of our thinking or the indifference of our attitudes, frequently we do not want what we get. Our distress is the greater when we remorsefully realize that we have no one to blame but ourselves.

Obviously the right of American citizens to determine the character of their nation and to

decide its destiny is attended by a tremendous responsibility. If when better decisions are to be made enlightened and well-disposed citizens will have to make them, then each of us and all of us must bend every effort to make certain that our judgments as a people and our policies as a nation will be as sound and as just and as advantageous to the general welfare as enlightened minds and dedicated hearts can make them.

The character and strength of the United States of America are entrusted to all of us who are its citizens. Whether our country prospers and flourishes or falters and fails is for us to decide. No citizen can neglect or evade his obligation to do his conscientious best or withhold his proper contribution to social and civic responsibility and leadership, without failing in his duty to himself and to his country.

The obligation to serve to the fullness of his bent and his abilities increases in proportion to a man's enjoyment of the advantages of education and personal influence. In consequence, the public duty of a doctor of medicine as a citizen to seek and to serve the true good of his country and of his people is second to no other duty.

Therefore, I call upon you to measure up to your social and civic responsibilities as citizens just as assiduously and conscientiously as you measure up to your professional responsibilities as physicians and surgeons.

It is no intrusion for a member of the medical profession to concern himself actively and intensely in the area of politics and the activities of government. Instead, it is an obligation in justice that he do so.

Through our organized efforts as members of the profession of medicine there is much that we have done and are doing.

For example, in New Jersey through our establishment and maintenance of the Medical-Surgical Plan (New Jersey Blue Shield) and our endorsement of the Hospital Service Plan (New Jersey Blue Cross), we have provided a splendidly effective means of enabling people of modest income levels, under a genuine application of sound insurance principles, to provide comprehensively and satisfactorily for their own health care needs, despite the increasing handicaps which relentlessly mounting taxes and ballooning inflation impose upon them.

Through our organizational efforts, we can and do evaluate proposed legislation—at state and national levels—as that legislation bears upon the true good of our citizens and our government.

We can and do make committees of members and officers of our society available for conference and consultation with officers and agencies of government—executive, judicial, legislative, or administrative. We offer and maintain ready liaison with the other professions, with social agencies and groups, and with the leaders of any and all authentic groups interested in the advancement and protection of the common good.

Through the American Medical Political Action Committee at national level and the newly-formed New Jersey Medical Political Action Committee within our state, we can and do encourage and support the programs of these aspirants for public office who have proclaimed their allegiance to principles of freedom and social justice.

But apart from these organized efforts of medicine, as citizens and as physicians there is more we can and should do. We should identify ourselves with the efforts of our local communities to discover and deal with local needs, especially as they affect the health, dignity, and freedom of groups of our fellow-citizens.

Perhaps the knowledge and judgment which you, doctor, can adequately supply are just what is needed to factor a presently puzzling community problem for effective and acceptable solution. Make it your determination that no community problem will fail of solution for lack of the help that you can bring.

A tendency has been growing in our country in recent years for individuals to serve only themselves, and to sponsor and support only those propositions which promise personal advantage. This niggardly and mean spirit is hostile to, and disruptive of, our unity as a people and our united strength as a nation.

It is characteristic of love that it seeks the

good of the one loved. But no one ever has had a successful and happy love affair only with himself.

Medicine is a great profession because with head and heart its worthy representatives have served their fellowmen so as to 'love and be loved in turn." Let us keep it such, so that it may be an inspiration and an example to all our fellow citizens. Our forefathers, with idealistic, unselfish, and generous spirit built a great nation for us to enjoy. As members of the profession of medicine and as citizens let us do all that we can to keep it so, so that our children—free, independent, and self-reliantly secure—may in turn commend our efforts and bless our memory.

2130 Millburn Avenue

Commission on Radiation Protection

To establish greater rapport with the members of our Society, the New Jersey Commission on Radiation Protection requested that one of our members serve as consultant to the commission. Dr. L. J. Levinson was nominated both by Dr. Louis S. Wegryn (President of The Medical Society of New Jersey) and by Dr. J. Bromberg (President of the Radiologic Society).

Pursuant to Chapter 116 P.L. 1958, the Commission on Radiation Protection is appointed by the Governor. Five of its members are chosen for their special training in physics, atomic energy, biology, and medicine. They serve without compensation and spend at least two days a month on the work of the commission. Two other members are *ex-officio*. They are the Commissioner of Health and the Commissioner of Labor. The commission is an independent body, which can propose, make, and amend regulations for radiation protection and rules to prevent unnecessary radiation exposure of the public. A public hearing takes place before any of the regulations are adopted and become the official code applicable to all who are operating x-ray equipment, and using radioactive materials; such as redium.

The present New Jersey Radiation Protection code consists of two sections: General Requirements and Special Requirements. This code became effective February 1, 1961, and is now a legal requirement. The State Department of Health is responsible for the enforcement of the Radiation Protection Code. All radiation equipment must be registered with the New Jersey Health Department under Chapter 116 (P.L. 1958).

Following registration the Health Department conducts inspections. If this indicates that the x-ray equipment and safety measures do not comply with the code, the owner of the equipment must correct these deficiencies; then there is a subsequent reinspection.

Reports of surveys must be filed with the State Health Department. Surveys on radiologic equipment must be done by a qualified individual and at the owner's expense. A list of acceptable physicists and other qualified individuals can be obtained from the Radiologic Health Program, Box 1540, Trenton 25, New Jersey. These surveys must be filed within 30 days of their performance. If alterations are made in previously surveyed areas or if new radiologic equipment is installed, an amended survey must be submitted.

An amended section, when finally adopted, will regulate the licensing and regulation of all radioisotopes used in New Jersey. These radioisotopes are under the jurisdiction of the U. S. Atomic Energy Commission. This may not become effective for at least another year.

The consultants may be called on by the commission for advice concerning the use of radiation equipment by the various specialties and organizations working in this field.

The consultants in turn can also propose to the commission revisions or deletions in the present or proposed codes.

LOUIS J. LEVINSON, M.D., Newark

William Furst, M.D.

East Orange

William Furst, LL.B.

Newark

Medical and Legal Responsibility in Clinical Research*

To avoid malpractice actions, physicians may be tempted to adhere to old established and "safe" methods and to avoid trying new ones. Such an attitude would put an end to medical progress. The problem needs clarification through the joint efforts of physicians, attorneys and pharmaceutical companies.

During the last decade, the American public has become increasingly litigation-minded. Insurance costs generally have mounted. Physicians are now confronted with increasingly frequent malpractice suits. A newspaper survey will reveal the proportions of the problem. Such headlines as "One out of 21 Jersey M.D.'s Sued for Malpractice"; "Effects of Drug Bring $600,000 Damage Suit"; "Wave of Malpractice Suits Hits Medical Profession"; "Why You Can Expect More $150,000 Malpractice Verdicts"; "Doctors Told to Double Liability Coverage" are anxiety-provoking.

The Federal Food and Drug Administration requires that the physician who does clinical research with new and unapproved drugs must sign an agreement with the pharmaceutical company. This assures the latter of his qualifications, hospital affiliations and the availability of a recognized clinical laboratory.

The authors[1] have previously suggested that, being so qualified, the researcher should require of the pharmaceutical company a written legal assurance—an indemnification agreement—guaranteeing the doctor protection against potential legal suits due to unanticipated side effects of the new drug with which he is clinically experimenting and not to his own negligence. The Law Division of the A.M.A. has likewise urged that a letter *in writing* be obtained from the pharmaceutical company to the effect that it will stand behind the physician and *indemnify* him against any loss he may sustain in such clinical research.

To the authors' knowledge no pharmaceutical company will enter into such an agreement. Attorneys, but few physicians, recognize the potential danger of clinical-pharmacologic research in the absence of such indemnification agreements.

In a sincere attempt to clarify current thinking we submitted the following questionnaires to 32 representative pharmaceutical companies:

Question 1. Does your company accept the proposition that the clinical researcher experimenting with a new and non-Federal Drug Administration-

*Presented at the Annual Meeting of the American Psychiatric Association, Atlantic City, N. J., May 1960.

approved drug is potentially liable to malpractice suit?

Question 2. If your legal department agrees, will they submit a recommendation that an indemnification agreement should be signed by the pharmaceutical company with the clinical researcher?

Question 3. Will your insurance carrier accept this in principle?

The following are responses from seven out of the 32 pharmaceutical companies:

Question 1. One agreed; five evaded the question; one "preferred not to respond."

Question 2. One responded "no." Three evaded the question. Three "preferred not to respond."

Question 3. One responded "no." Three evaded the question. Three "preferred not to respond."

The issues of responsibility in clinical research have recently been emphasized by attorneys. Ladimer[2] draws attention to the fact that no statute specifically prohibits, regulates or governs medical experimentation *per se*. Nevertheless, "experimentation" in the context of legal decision has been considered an element of malpractice. He stresses that physicians may experiment if successful; but are liable if they fail.

"In addition, for practical purposes a major issue relates to consent. Blackstone is quoted as follows: 'It is a basic principle of constitutional law that every person has the right to protect his health as he deems best as part of his fundamental personal liberties.' Any unauthorized invasion constitutes ground for civil liability. To be free from other than that arising from negligence, the researcher who employs a person in his research must obtain valid consent. Malpractice cases are replete with illustrations of restraint on physicians where there is no clear voluntary assent."[2]

Hershey,[3] warning that most insurance policies will not cover intentional legal battery in an investigative procedure, submitted the following conditions for consent:

(1) The person must be competent mentally and of mature age, so that he may understand the implications of the proposal.

(2) He must be aware at the time consent is sought that certain harmful and discomforting results may follow.

(3) He must be aware of the nature of the procedures; that they are not always perfect, and that complications may arise.

(4) Consent of persons other than the patient may be required.

The clinical researcher immediately reacts negatively against such proposals.

(a) How, he asks, will one obtain clinical material not subject to anticipatory anxiety (which would influence base line evaluations) if the patient is informed of potential dangers in research?

(b) What is the liability of the researcher to inform the patient of the use of placebo controls—an obvious deception?

(c) Will not such restrictions hamper *bona fide* structured research?

Ladimer[4] states, "Economic, legal and publicity pressures, not professional judgment, have convinced physicians to remain with the conventional and therefore 'safe' methods. Rather than risk legal action they risk medical inaction." The researcher, should he exceed the limits of drug usage as prescribed by the drug house (doses frequently being inadequate for therapeutic effect) may be "on his own" should adverse reaction occur. "It is inevitable" concludes Ladimer[4] "that legally, with appropriate acknowledgment of the place of experimentation, there can be a recognized sphere for such activity."

Is it not then appropriate that physicians, pharmaceutical companies, attorneys and insurance firms come to grips with these issues? Attorneys have already drawn attention to this subject.

At the National Conference on the Legal Environment of Medical Science, Reverend T. J. O'Donnell[5] stated, "It has been the finding of our session that the application of law to health research on human subjects has developed on a case by case rather than on a statutory basis. *The law has not kept pace with modern medical development* so that present-day investigative procedures are likely to be evaluated under legal principles of another century. Courts should be encouraged to lean upon the principles established by reputable public

and private organizations for the legal safeguarding of physicians and patients in modern investigative procedures and human experimentation. To establish an inflexible statutory system might result in unreasonable limitations upon modern research methods."

Ladimer[4] further emphasizes, "The drug house may be liable without proof of negligence for harm caused by the use of drugs under investigation, under doctrines of liability without fault. These base liability on the social insurance principle of placing cost where it can best be imposed in our society. The principle as assumption of risk invoked in ordinary malpractice is regarded by some as applicable to the research context but a definitive answer is yet to be given. It would depend on the degree of comprehension of an experiment and the probability of extending the thesis of absolute liability as a social policy."

Our presentation focuses attention on the overlooked legal liability of the physician in clinical research. The problem is complex but clarification of the issues raised by attorneys, physicians, insurors, and pharmaceutical concerns is long overdue.

SUMMARY

1. Malpractice litigation is becoming increasingly frequent.

2. The Federal Food and Drug Administration requires a written verification of the clinical researcher's qualifications.

3. The clinical researcher, being so qualified, *should require an indemnification agreement in writing* from the pharmaceutical company guaranteeing him protection against legal suits from unanticipated side effects of drugs used.

4. To evaluate the viewpoints of attorneys, pharmaceutical and insurance companies concerning this issue, a questionnaire was sent to 32 drug companies. Not one single company would commit itself to reply specifically to the questions raised.

5. Attention is drawn to the importance of this problem to the uninformed clinical researcher.

6. The complex nature of liability in clinical research urgently requires a clarifying collaborative effort from the vantage point of attorneys, insurors, physicians and pharmaceutical companies.

49 South Munn Avenue

BIBLIOGRAPHY

1. Furst, W. and Furst, W.: Diseases of the Nervous System, 22:132 (February 1960).

2. Ladimer, I.: International Record of Medicine, 172:586 (October 1959).

3. Hershey, N.: Bulletin for Medical Research, 13:3 (October 1959).

4. Ladimer, I.: Op. cit, reference 2.

5. O'Donnell, T. J.: Bulletin for Medical Research, 13:4 (October 1959).

Radioisotope Training

Physicians desiring training and experience in the diagnostic application of radioactive isotopes may apply for admission to the course at Oak Ridge (Tenn.) Institute of Nuclear Studies. The program is divided into basic preclinical and clinical instruction. Whether the phases are taken in successive weeks or over a longer period is dependent on the registrant's convenience. Applicants must be holders of licenses to practice medicine in this country.

Further information on fee schedules, course content, and so forth, is obtainable from Special Training Division, Oak Ridge Institute of Nuclear Studies, P. O. Box 117, Oak Ridge, Tenn.

SAMUEL C. SOUTHARD, M.D.

Ventnor

The Role of the Family Physician in Accident Prevention*

If the family physician will not take the leadership in accident prevention, some other group will. Here is a challenge to all of us.

THE role of the family physician in accident prevention has been my medical hobby for the past ten years. My interest in this field was aroused when I realized that more children were being killed and injured by accidents than by disease. Thus, in 1960, some 13 million children sought medical attention as a result of accidents. Annually, 50,000 to 60,000 children are permanently injured and 15,000 to 16,000 children are killed by accidents.

If any disease were responsible for these data, there would be a nationwide organization with local branches in each hollow and hamlet devoted to this problem and striving for a solution. Yet, in our country, where we have one of the most progressive and least fatalistic cultures in history, there is a peculiar lethargy regarding accident prevention. You are all aware of the furor that occurs when one child in a neighborhood develops poliomyelitis or infectious hepatitis. Can you imagine what benefits would accrue if similar interest could be developed in accident prevention?

The family physician enjoys the faith and admiration of his patients. He is respected as a healer and for the fact that the attainment of his medical knowledge and skill required above average effort, intellect and integrity. The accident prevention problem is one which our family physicians can help solve by virtue of their treasured position in the community and their education.

The function of the family physician in accident prevention can be divided into four categories: His role in his office, in his community, in his hospital and in his leisure time.

IN THE OFFICE

IN HIS office, the family physician or pediatrician sees infants on a monthly basis and children on a two to four times a year schedule for examination, immunizations and health conference. I suggest that one of the matters discussed be accident prevention. Start when the baby is three months old. By this time, the baby and mother are getting to know each other, are better adjusted than in the first weeks and the usual newborn problems of hunger, constipation, colic and maternal anxiety have subsided. This is an opportune time for a chat on accident prevention. The salient features can be covered in three to five minutes,

*Presented April 7, 1962 at the Symposium on Child Safety sponsored by the Committee on Child Health of The Medical Society of New Jersey.

ending with the distribution of printed literature pertinent to the child's age. This type of short but worthwhile patient education should be repeated at 12 to 13 months of age and thereafter at least once a year.

The physician who sees children in his office has a busy waiting room. This is because each patient is accompanied by one or more persons. This includes parents, siblings, grandparents, friends, or nursemaids. This is an opportunity to utilize effectively the time these people spend in the waiting room. This can be done by poster exhibits, educational material on the magazine shelf, bulletin board topics, give-away literature and finally the good example of a safe office.

IN THE COMMUNITY

THE physician, as a member of his community, should set a good example by adhering to principles of safety in his everyday life. For instance, the physician who regularly uses a safety belt in his car makes a good impression on his patients and stimulates them to think constructively about accident prevention. Almost every medical practitioner, at some time in his career, is asked to serve on the governing body of some organization with children's activities such as Boy Scouts, Y.M.C.A., Community Center, summer camps, or a social agency. This gives him the opportunity of propagating accident prevention with the professional personnel.

Each community has its own peculiar hazards, such as water, cliffs, high speed roads, etc., which threaten children. If inadequate safety measures exist, this doctor can motivate community action to greater protective measures. Then, too, the physician can stimulate a comprehensive community campaign on childhood accident prevention. In these campaigns, the usual role of the physician is that of catalyst and consultant. Many service clubs are willing to conduct child safety campaigns if someone would direct their efforts. The Accident Prevention Committee of the New Jersey State Chapter of the American Academy of Pediatrics has a printed plan for such a program.

IN THE HOSPITAL

THE community hospital is usually the center of that area's medical endeavor. If there is no nearby Poison Control Center, the physician should establish one in his hospital. Information necessary to begin such an operation can be obtained from the American Association of Poison Control Centers, the Subcommittee on Accidental Poisoning of the American Academy of Pediatrics and the State Department of Health. Other hospital activities include educational programs for the medical staff, interns, nurses and nurses' aides. Utilization of the statistics compiled by the hospital on accidents treated, number and types of poisons treated and other such information as the basis of newspaper and radio releases prove valuable in educating the public.

DURING HIS LEISURE

IN HIS leisure, the interested physician finds much to do in this field. The scope of the problem is limitless and its complete solution is impossible. The physician can contribute articles to medical and non-medical publications, prepare news releases, radio speeches, exhibits and form or join an accident prevention group. Research is needed in many directions; for example, many of the new complex organic solvents and insecticides have no known antidotes. The question of whether to use gastric lavage in kerosene ingestion is still unsolved. No one has proved that the automobile safety belt recommended for adults is as efficient for children. For those who think that research requires a multidigited budget with a huge staff and laboratory, remember that Jenner's work with cowpox virus consisted of years of observation and thought and two experiments two years apart.

WHY OUR APATHY?

At the present, only a small number of physicians are active in accident prevention. This is due to one or more of the following reasons:

1. Greater interest in some other medical field as a professional "hobby."
2. Too busy with current obligations.
3. Feeling that accident prevention is a "paramedical" activity.
4. Feeling that enough work and publicity have already been expended on this work.
5. Lack of interest because time and effort spent in accident prevention are not commensurate with acquisition of greater medical knowledge and skill that can be applied to private practice.

Segments of organized medicine interested in accident prevention are directing most of their efforts toward their members, that is, the doctors, and through government agencies. In years to come, the participation of physicians will increase; but we deal with the present. I don't believe that the average man knows that *accidents comprise a greater threat to his child than disease.* Is the lethargy about accident prevention due to a lack of knowledge?

Organized medicine should carry this accident prevention work directly to the public in addition to working through their members and federal and state agencies. My recommendation is that the American Medical Association, The American Academy of Pediatrics and the American Academy of General Practice appoint a joint committee as a task force to study how to publicize accident prevention and to carry a campaign directly to the public.

7217 Atlantic Avenue

Interested in Medical Communication?

If you are interested in medical writing, educational editing, publishing, or any other aspects of medical communication—then you may profit by becoming a member of the American Medical Writers' Association. Now 20 years old, this national professional society is made up of people interested in medical communications. It stages an annual convention (Chicago in '63; Philadelphia in '64); provides a medical manuscript editing service and a national placement service for members; grants awards and certificates for outstanding accomplishments in medical writing and editing; judges medical writing contests, maintains a roster of lecturers on medical writing, and offers scholarships for people contemplating a career in this field.

AMWA publishes a monthly Bulletin as well as pamphlets on various aspects of medical writing. Chapters are active in the metropolitan New York and Philadelphia areas.

AMWA membership includes editors and publishers in medicine, dentistry, nursing and allied professional groups; writers and editors associated with hospitals, pharmaceutical companies, foundations, publishing houses and advertising agencies—and many physicians who are interested in problems of medical communications, or who just want to write more effectively. Dues are $10.00 a year. If you want further information, write to the AMWA at 250 West 57th Street, New York City, 19.

Perils of Mail Order Pharmacies

Doctors should urge patients to think twice before succumbing to the temptations of mail-order economy in pharmaceuticals. The delays inherent in mail-ordering as well as the uncertainty as to what is delivered—and when—should convince the reasonable patient that he is ahead by having his prescription filled by his regular local druggist.—Editorial in *Wisconsin Medical Journal,* March 1962.

Robert S. Garber, M.D.

Belle Mead

Treatment of the Ambulatory Schizophrenic*

Many stubborn patients, called hypochondriacs or neurotics, are really compensated schizophrenics. Dr. Garber here sets up diagnostic and therapeutic guide-lines.

The phrase "ambulatory schizophrenic" was first suggested in 1941 by the late Gregory Zilboorg.[1] The justification for the term is this:

Certain odd and difficult people seldom reach the point at which hospitalization appears necessary. These people seem "to walk about life" like any other "normal" person—although they remain inefficient, casual in their ties to things and to people, and tenacious only in their inability to be productive and independent. They pass as 'difficult people' or as 'problem children.' Adult or adolescent, they are irresponsible enough to remain dependent; yet strong enough to appear sound of mind and limb. They often have hypochondriacal complaints and tendencies to minor chronic ailments such as, endless colds. Such individuals remain more or less "on the loose" in the actual or figurative sense, outwardly and inwardly; hence the suggested designation of "ambulatory schizophrenia."

Brody,[2] 20 years later, offered a unique definition of the same concept: "Almost everyone called schizophrenic is ambulatory in the sense he is able to move around. If he lives outside of a hospital he may initially appear less sick than his hospitalized brother. He may present a facade of relative normality, because his social milieu requires it and makes it easier for him to do so. His psychotic tendencies may become clinically overt under stress. Those tendencies may be suspected by others, but are often clear only to members of his family or those who know him intimately." These ambulatory schizophrenics are also called 'latent', 'incipient', 'pseudo-neurotic', or 'pseudo-psychopathic' schizophrenias.

An ambulatory schizophrenic can for years receive medical treatment without being properly diagnosed until this process is specifically looked for. One might ask, 'Why bother to make a specific diagnosis?' The reason is this: diagnosis does point the way to appropriate treatment. If it were not for this, it would make little difference whether an accurate diagnosis was made. Hellender[5] firmly believes that the treatment for 'hypochondriacal neurosis' and that for 'ambulatory schizophrenia' is vastly different. This view is strongly supported by others who have managed similar problems. A case study[3] revealed: "With this patient, after he had been accurately diagnosed, more appropriate plans could be made for his treatment. After he had been in treatment for

*Read by invitation at the seminar for general practitioners, Kansas City (Mo.) Neurologic Hospital, April 29, 1962. Dr. Garber is medical director of the Carrier Clinic.

a year, it was observed that he had not requested appointments in the other departments of the hospital." This fact was pointedly made since prior to diagnosis he had been in every medical clinic of the hospital. Ambulatory schizophrenics present an appearance of relative normality or of superficial psychoneurosis. This is merely a mask to cover the presence of ways of thinking and feeling when defensive anxiety-reducing technics are limited. Such a person erects barriers between himself and "feeling" when defensive anxiety-reducing technics are limited. He also throws up walls between himself and anxiety-provoking situations as well as between himself and other people. Thus, he reverts to less mature ways of thinking, feeling, and acting under stress. The subjective experience may be dominated by intense anxiety or by attempts to make sense out of his inner chaos through the formation of delusions or hallucinations. His coping mechanisms may result in an inner experience of boredom, restlessness, dissatisfaction with life, feelings of emptiness or lack of identity. Sometimes his life can be punctuated by flare-ups of suspiciousness or aggressive excitement, but is often flat to the point of desperation.[3] Under these circumstances, he tends to withdraw from external events and people. So he becomes pre-occupied with his own body and its functions. The latter is sometimes understood as a regression. Nevertheless, as he becomes more settled on physical discomfort he eventually turns to a physician—not to a psychiatrist—but to a "real doctor" who can relieve him of his undue concern about his body and upon whom he can be comfortably dependent.

These sensitive people are never entirely sure that they are appropriately received or loved by anybody; consequently, with the passage of years, such individuals are inclined to expect disappointment and rejection. To protect themselves from disappointment and rejection, they become cautious in developing relationships with people. They are ever mindful of the necessity to withdraw from any association or to utilize defensive mechanisms like hostility and aggression in the face of any frustration. Such an individual usually fits into that class of patients who calls upon any new physician in a community and begins to make the rounds of doctors looking for something 'new' which is frequently that which the physician cannot supply. As a result, we often find that the ambulatory schizophrenic is not usually ready to relate to the doctor in the same way as other patients might. If, for example, he presents the appearance of being ready to flee or displays feelings of hurt or irritation, the doctor, in turn, may then feel rejected or rebuffed and, consequently respond with an annoying gesture or similar non-verbal communication, or he may treat the patient with disinterest or detachment. As a result of renewed rejection, the patient makes rounds to the physicians' offices undergoing endless physical examinations, history taking, x-rays, and laboratory studies. Consequently, it is essential that the practitioner recognize the problem with which he is dealing. If he is successful in this respect, he must *then* decide if he wishes to try to interrupt the patient's journeying from one physician to another. Brody [2] suggests that "therapeutic modesty" should be the yardstick. "The doctor's decision to deal with the ambulatory schizophrenic in his medical practice involves a decision to 'manage' in a sense that he is the manager for patients with diabetes or heart trouble or other chronic difficulties rather than to 'cure' in a sense of surgical excision or antibiotic treatment."[2]

The physician must next determine what areas of the body require further investigation. Bodily complaints must be investigated in the customary way. Elaborate tests and examinations, not specifically indicated (but considered simply for the sake of "completeness") are not recommended. Too often the demand for an extensive work-up is only the patient's way of seeking security in physical measurements and of avoiding the real problem because of the doctor's anxiety about it. Some undesirable results can follow from diagnostic procedures pursued to an intensive degree. Frequently the physician managing such a case is tempted (in the absence of any positive finding, as a result of his study) summarily

to dismiss the patient with the statement, "There is nothing wrong with you" or that "It is all in your head." The more convinced the patient is that he has a bodily disorder, the less likely he will be to accept a statement that he is in need of psychologic help. Should the physician at this point express unwillingness to enter into a treatment relationship with the patient, it is then essential to see that such a referral is managed appropriately. Some patients simply will not accept referral to a psychiatrist. The recommendation should be presented in such a way that the patient departs from the office feeling that he is *going to* something rather than just being rejected or "tossed out" of the physician's office.

On the other hand, many patients derive much from a supportive approach in which the physician evinces a willingness to listen and to be helpful. This need not be extremely time-consuming. Such appointments may be spaced in the beginning, for several times a week, then fairly rapidly stretching the appointments to once a week or once every two weeks, eventually to once a month. These contacts, though brief, may be more meaningful to the patient than the physician ever realizes. The practitioner would do well to make certain that he can provide a warm, relaxed, confident, and optimistic relationship in which very well-structured goals of treatment are set in the initial interview.

Within the last 18 months, I saw a brilliant research scientist who had regressed after several "rejecting interviews" with various physicians to the point where he felt worthless, penniless, pre-occupied, unable to carry out the simplest assignments. He met the therapist initially with a cold indifference and in a tone of mockery stated, "Doctor, I don't know why I am here. I don't know why you would even consider wasting your time, I can't pay you. I am already a lost soul, my 'so-called brilliance' has already spluttered out, and there are no prospects for my ever becoming well again." He was, in a kindly manner, reminded that the therapist was neither interested in the fact that he was penniless nor friendless, but much interested in him as a human being; that the therapist did not believe the brilliant scientist was down the drain but rather temporarily side-tracked; and that the therapist fully intended to guide him safely back on the track without further delay. The patient responded with a look of disbelief. After considerable hesitation, he asked the therapist to state the goals of treatment again. The patient found it difficult to believe that any person would be actually interested in his welfare (although he wanted to believe that such was the case) and very cautiously, yet timidly, agreed to return the following day. After three visits the "rejuvenation" of this "lost soul" was such and his entire demeanor was altered to such a degree that his employer called to inquire what "magic potion" had been injected to have accounted for such a considerable change. His progress has continued and presently he has his old position back. This is, of course, not always the way in which therapy works with patients who might be listed under the label of ambulatory schizophrenic.

The "transaction" within the doctor-patient relationship may be much more meaningful and significant than the physician is aware of at the time. Any relationship which provides support, friendliness, and a willingness to help should not be written off too lightly. Especially is this so if one person in the relationship also carries the prestige which belongs to a practitioner of medicine.

In the beginning, directive supportive therapy is essential. Later this may become less directive and more probing. Such probing initially should refrain from moving into the highly charged areas of loves, love-life, or sex. When therapy does get into this realm the stage has actually been already set for an approach on an informal basis at which time the therapist may relate factors of a very personalized nature—perhaps by relating parts of his own history or experience or symptoms.† The therapist must be forbearing enough himself to accept limited goals for the patient. Frequently the overly ambitious therapist may push his patients into relapses because of his

own aggressiveness. Such a disorder cannot be managed like an infectious disease in which an antibiotic will bring the process to a more or less speedy termination. The goal may be to keep the patient functioning in society. At times, it may not even be *to relieve* symptoms but simply to help the person *to live with* his symptoms. Symptoms are notably found to be a guard against a schizophrenic anxiety. The doctor should not be discouraged when one symptom is 'removed" and another appears. At this point it is essential that the therapist make it clear to the patient that the physician is on his side, wishing to help the patient find himself in terms of external reality, especially in the areas of his work, his love-life, in all of his interpersonal relationships.

Ambulatory schizophrenic patients have very tenuous relationships with others. They cannot well-afford any change in the doctor-patient relationship which might be interpreted as rejection or even the slightest rebuff. It is always advisable gradually, rather than precipitously, to change time intervals between appointments. If the doctor anticipates that he is going to be away for anything more than a brief period, notice should be served on the patient well in advance so that any doubts he has (regarding the absence of contact with the therapist) can be adjusted and worked out long before the therapist's departure.

Miller[4] has stressed the importance of a "conservative" approach. He suggested that one of the physician's major tools (in addition to his interest, willingness to listen, his reassuring manner, and the application of supportive psychotherapy) is his "refusal to be frightened or hurried into some kind of 'do something' treatment."

Hollander[5] reminds us of the truism that "action may cause harm whereas relative or apparent inactivity may be the treatment of choice."

Upon completion of the initial work-up (including a certain amount of cautiously gathered personal information) the doctor will have an idea about the problem at hand. He should *not*, however, undertake to "manage" such a problem unless he is prepared to go "*all the way.*" This includes a willingness to be available when called. These people should not be put off when they call. Willingness to chat for a few moments can do more to prevent a full-blown panic situation than several hours in a less tension-ladened situation. The goal is to create a situation in which the patient can incorporate the interviews into his own defensive system. This does not contemplate long interviews in which the patient freely rambles on doing most of the talking while the doctor sits idly by. Such an approach frequently weakens the patient's already shaky defensive system and his ability to hold on to reality. The wise therapist bolsters the patient's defenses and keeps him functioning, even though this seems to be marginal, for the greater part of the time. Thus a practitioner will see the patient for short visits, maybe 15 to 20 minutes; but will see him often enough to develop a relationship which is not threatening to his proximity to the patient and one in which there is an even exchange between the two. This way the patient does not hesitate to talk about himself. This is particularly so, if he can emphasize common interests with the patient. This helps to bridge the void frequently found between patient and therapist. The therapist must understand that frequently the schizophrenic's great problem lies in the field of communication in two areas:

1. He never really knows what another person is thinking or what feelings the other person has because he, himself, thinks and feels in a totally different way.

2. He usually has a language all his own. His ability to coin words that meet his purpose frequently confounds the receiver until the latter gets "in the same wave band."

Since the patient requires feed-back, principally because he has had trouble in the past deciding who people are, what they really think of him, the doctor should present himself not only as a real person but one who

has had somewhat similar experiences and has been able to work them through.†

The physician should never hesitate to use medication when he believes it is necessary to be supporting. The judicious use of chlorpromazine has been found helpful but carries with it the necessity to explain symptomatic side-effects well in advance of his prescribing the drug. If it were not for chlorpromazine, the staffs of our hospitals would be even more overwhelmed than before. This medication is tremendously effective in bringing under control innumerable symptoms that the schizophrenic presents in everyday situations. It is valuable in heading off panic reactions. It is an important drug to maintain the schizophrenic on an indefinite basis.

Sometimes the therapist is confronted with a crisis in the management of the patient, such as an acute flare-up of any delusional material, intense pre-occupation with bodily ailments, or a panic reaction. The physician should then admit his patient to a general hospital environment. This is better than plunging him (through a voluntary or regular commitment) to a large psychiatric hospital; for all too often, this suggests that the doctor has admitted defeat by sending him into a completely psychiatric environment and frequently precipitates a severe psychotic break. When the physician's effort is directed towards maintaining the patient's defenses by arranging for a prompt return to the community with a minimal residence in a general hospital environment, he can generally avoid the recurrence of such crises. Brody[2] adds that the doctor's major problem in escorting this patient through life, is contained in the old adage "Physician know thyself." This means being able to identify one's own responses to an annoying, frustrating, frightening, and puzzling patient; and the ambulatory schizophrenic can be all of these.

Frequently, patients are able fully to accept the explanations of their illness with a good knowledge of the symptoms pointing to the possibility of an acute exacerbation; consequently, they are able to take somehow a more "realistic" view of their illness. Thus, they are eager to keep contact and to keep the symptoms controlled.

One patient, a chemist, calls a member of our staff as soon as he recognizes the emergence of delusions. He promptly arranges to come in for a visit. Here the medication is appropriately adjusted and support rendered. In this manner, the man has been able to work regularly without interruption over a period of many years.

Another, a nurse, calls the same physician when she develops tension and feelings of depersonalization. Together, they have found by experience, that medication alone does not prevent recurrence. Thus, she calls saying that she feels the need for a prompt office visit, even to the point of knowing when she requires an out-patient shock-treatment. She knows her symptoms well enough to be correct in this area, for recurrences happened some years ago when she did not follow that plan.

Self-knowledge in this sense will help the doctor avoid behavior which the patient interprets as rejection or an eager effort to treat, which the patient may experience as seduction or the fostering of his expectation for concrete care which cannot possibly be fulfilled. It will also keep him alert to the prodromal signs of an acute psychotic flare-up. The physician should remember that "in the conduct of therapy, the patient is frequently eager to relate to the therapist, but is frightened, confused, and unaccustomed to having his perceptions, ideas, feelings and motivations listened to with any great interest or with an effort to understand them on his terms."[6] Often the problem involves conventions or beliefs taught in early childhood and never accepted, but also never repudiated. These conflicts have to be brought to light.

Hulse[7] finds that most patients selected for this therapeutic approach do respond well and have shown a decrease in depressive and fear-

†If Dr. Garber means that the physicians should talk about his own (the doctor's) experiences, many psychiatrists will disagree—Editor.

ful feelings, a greater closeness to reality, an increase in social activity and responsibility, and improved interpersonal relationships. Thus, this can be a rewarding experience for one willing to accept the challenge of office treatment of the ambulatory schizophrenic patient.

The Carrier Clinic

BIBLIOGRAPHY

1. Zilboorg, G.: American Journal of Orthopsychiatry, 27:512 (May 1957); also *Psychiatry*, 15:149 (Feb. 1941); also American Journal of Psychiatry, 108:678 (Dec. 1956).

2. Brody, E.: *Psychosomatics*, 11:666 (December 1961).

3. Bessel, D. and Mazzanti, G.: Psychiatric Quarterly, 33:189 (March 1959).

4. Miller, M. H.: Annals of Internal Medicine, 44:736 (July 1957).

5. Hollander, M. H.: Journal of Chronic Diseases, 2:167 (March 1959).

6. Powdermaker, Florence: *Psychiatry*, 26:156 (February 1952).

7. Hulse, W. C.: Archives of Neurology and Psychiatry, 79:617 (June 1958).

Vaccinia Immune Globulin

A program for the preparation and distribution of vaccinia immune globulin (VIG) has been established by the American National Red Cross in cooperation with the Armed Forces. This hyperimmune gamma globulin is prepared from recently vaccinated servicemen. It contains a high titer of antibodies effective in arresting abnormal infections with vaccinia virus, the agent used in vaccination to produce immunity to the dangerous virus of smallpox.

The importance of universal vaccination against smallpox has been demonstrated repeatedly. Thousands of cases continue to occur in parts of the world in which precautions against the disease are inadequate. Universal vaccination is more important than ever because of rapid world-wide transportation.

The American National Red Cross has a program for the production and distribution of VIG. Since the scanty supply of this rare blood fraction could be dissipated if it were used when not indicated, seven physicians on the staffs of prominent medical colleges throughout the country have been appointed as volunteer consultants. Any physician who feels that VIG might be required for a patient should telephone the nearest consultant.* If the condition of the patient will benefit from treatment with VIG, the consultant will authorize its shipment from the nearest regional blood center.

VIG is not indicated in (1) cases which are not vaccinia, such as chickenpox, herpes zoster, etc.; (2) normal vaccinations disturbing to the patient because of the febrile reaction, pain and swelling with normal primary "takes"; and (3) trivial secondary inoculations on nonvital areas of the body. VIG is effective in preventing the disease or diminishing the severity of smallpox in individuals who have had close contact with smallpox. It is effective in the rare complications from vaccination (the most frequent of which is accidental inoculation into the eye resulting from a child touching the vaccination and then putting his finger in his eye). Early treatment with VIG will result in a marked improvement within hours and prevent possible loss of vision. Special care should be taken in vaccinating children if they have brothers or sisters with eczema because of the likelihood that they might develop vaccinia lesions on their affected skin areas, "eczema vaccinatum." Before VIG was available this condition carried a high mortality rate in very young children, but now adequate treatment arrests this disease. Very rare individuals lack the normal body defenses against infection and may develop generalized vaccinia or vaccinia necrosum; VIG is the only specific treatment for these conditions.

A report form will accompany each shipment of VIG, and the physician is requested to return it.

*In our area, call one of these numbers:

(1) Dr. Henry Shinefield, Hawthorne (N.J.) 7-7127

(2) Dr. Henry Shinefield, ext. 7428 at Trafalgar 9-9000 (New York City)

(3) Dr. Heinz Eichenwald, Hastings (N.Y.) Phone Greenleaf 8-3264.

Hugo O. Gelmann, M.D.

Stuart R. Silver, M.D.

A. M. Sabety, M.D.

Orange

Artificial Production of Intra-Arterial Thrombosis*

To appraise fibrinolytic agents, it is necessary to try them on clots. The Ewing Heart Unit here shows a simple technic for artificially producing intra-arterial thrombi in experimental animals.

The evaluation of the *in-vivo* activity of the fibrinolysins has been delayed and confused by the difficulties presented by the experimental production of intra-arterial thrombi. The production of thrombi under laboratory conditions should imitate closely the usual histo-pathologic process, and the method should be reproducible to allow reliable investigation of the many variable factors involved in fibrinolysis.

Several ways of producing intravascular thrombosis have been described, such as the serum-inducing Wessler clot,[1] and traumatic injury of the intima or chemical irritation with sclerosing agents.[2,3] They are all effective in the production of intravenous thrombosis. In arteries, however, we found them, in our own experience, unreliable.

Drs. R. I. Clarke and E. E. Cliffton directed our attention to a method utilizing electricity. The theoretical basis for this method was described by S. Schwartz[4] who demonstrated that an electrical potential exists normally between the lumen and the environment of blood vessels and that alterations of this potential either cause or prevent thrombosis according to the direction of the electrical current.

This paper describes a method to induce intra-arterial thrombosis as we developed it during our studies of fibrinolytic agents.

METHODS AND MATERIALS

Mongrel dogs of both sexes were used, weighing 20 to 22 kilograms. After premedication with chlorpromazine hydrochloride (25 to 50 milligrams) the animals were anesthetized with pentobarbital sodium at a dose of 25 milligrams per kilogram of body weight, intubated, and placed on a Moerch respira-

*From the Research Laboratory of the Ewing Heart Unit, The Hospital Center at Orange, Orange, New Jersey. This investigation was supported by Grant No. 193C from the Heart Disease Program of the State Department of Health, Trenton, New Jersey. Dr. Gelmann is a Fellow in Cardiology, Orange Memorial Hospital, Orange, N. J.

1. Wessler, S.: Journal of Clinical Investigation, 34:647 (1955).
2. Cliffton, E. E., Grossi, C. E. and Canamela, D. A.: *Blood*, 9:310 (1954).
3. Reid, W.: Archives of Surgery, 84:34 (January 1962).
4. Schwartz, S.: Surgery, Gynecology & Obstetrics, 108:533 (May 1959).



Figure 1.

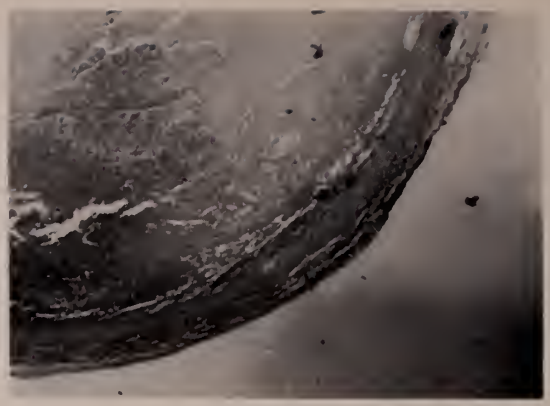


Figure 2.

tor. An intravenous infusion of 5 per cent glucose in water with 5,000,000 units of penicillin was started in a front leg. Both inguinal regions were prepared, and the common femoral artery was exposed with its side branches and bifurcation. The vessel was insulated from the surrounding tissue by a thin polyethylene sheet, and two rubber shunt clamps were applied approximately 30 millimeters apart from each other. The current was supplied by an 18-volt battery in circuit with an adjustable resistance and an amperemeter. This enabled us to maintain the electrical flow constant at 10 milli-amperes. In the early stages of our experiments we attached both poles of the battery to the wall of the artery by means of steel or silver wires. This, however, caused too severe a cautery effect and tissue damage, so that formation of aneurysm or complete necrosis of the wall developed subsequently. We then used thin aluminum sheets measuring 15 millimeters in width which are easily available as "O-R Disposable Conducto-Heel Strips No. 11."

These aluminum strips were wrapped around the circumference of the artery and held in place by plastic tubes which were split at the end. (See Fig. 1) One pole of the battery was attached to this circular electrode while the other was connected to a remote body surface electrode. Thus the artery was exposed to the negative pole for half-an-hour and then to the positive pole for another half-an-hour. By exposing the vessel to the negative pole first we tried to get enough tissue damage to the wall of the vessel and to the intima in particular in order to anchor the thrombus to the wall as occurs in diseased vessels. The exposure of the stagnant blood column to the positive pole then caused firm thrombosis. To assure good connection between the blood clot and the wall of the artery we had to apply a temporary ligature proximal to the thrombus formation, since the thrombus had to withstand the high arterial pulse pressure wave in our otherwise healthy laboratory animal with good peripheral circulation. For this purpose we wrapped a thin plastic sheet around the vessel and tied a heavy silk suture over it. Then the clamps and electrodes were removed and the wound closed in layers. After three to seven days the dogs were prepared and anesthetized in the same way and the incisions were re-opened. The ligatures now were removed and the presence of intra-arterial thrombi was confirmed by inspection, by direct blood pressure readings distal to the clot formation and by angiograms. Due to our experiment with fibrinolytic agents some of the clots were lysed at this stage. Others were used as controls and left intact. The dogs survived another three to ten days, after which time we examined the arteries for persistence of the thrombosis as well as for patency of the site of previous thrombolysis. Angiograms were taken again and the specimens were resected for direct inspection and histologic examination.

RESULTS

Our series included 20 dogs. We attempted intra-arterial thrombus production with the method above described in 24 instances, all of which were successful.

After removal of the circular electrode from the vessel no external damage or cautery effect was visible. Within the lumen a black thrombus could be observed, measuring about 30 millimeters in length and four to five millimeters in diameter, according to the thickness of the vessel. After the temporary ligature was removed there was a firm thrombus well attached to the wall withstanding the high ar-

terial pressure. Complete occlusion of the lumen was demonstrated by angiograms. Histologic examination of the resected specimen showed a thrombus of normal architecture within the lumen of the artery with necrosis of the intima and parts of the media. (See Figure 2.) Some of the thrombi were left in place as controls for another three to six days and in all instances, firm, occlusive clots were present on re-examination as was confirmed by repeat angiograms, direct inspection, and histological examination.

The technic here described offers a reproducible method of producing intra-arterial thrombosis. Since no mechanically or chemically irritating substances are introduced into the lumen of the vessel, physiologic clot formation is achieved. Utilizing an electrical current, we believe, closely simulates the natural phenomena of arterial thrombosis and yields a reliable substrate for studying the new thrombolytic agents.

SUMMARY

A RELIABLE method to produce intra-arterial thrombosis is presented which is the essential condition for the evaluation of fibrinolytic agents. The technic uses an electrical field for the induction of thrombosis. Results are illustrated by angiograms and histologic sections.

144 South Harrison Street (Dr. Silver)

Breast Cancer

An anaysis was made of 541 cases of breast cancer seen over a 30-year period. The absolute five-year cure rate was 30 per cent, and the absolute five-year survival rate was 36 per cent. The cure rate of patients treated by radical mastectomy was 34 per cent. When symptoms had been present longer than two months the tumors were larger, the frequency of axillary involvement was greater, and the cure rate was lower. Tumors smaller than two centimeters (pathologist's measurement) were associated with a cure rate of 53 per cent; those larger than two centimeters had a cure rate of 29 per cent. Axillary lymph nodes were histologically involved in 59 per cent. The cure rate in patients treated by radical mastectomy in whom no axillary involvement was present was 50 per cent; this fell to 25 per cent when axillary nodes were involved.

C. H. Zug and K. H. Cretzmeyer, Arch. Surg., 84:480 (April, 1962).

A Day at the Shore

Here's a chance for you to spleand a pleasant July Saturday in the air-conditioned auditorium of the Fitkin Memorial Hospital in Neptune. The program starts at 9:15 a.m., July 20, with a paper on pathologic fractures by Dr. Frederick Thompson, chief of orthopedics at St. Lukes in New York. At 10 a.m., Dr. Harold Dargeon (clinical professor of pediatrics at Cornell) speaks on leukemia. Dr. Alvin Goldfarb speaks on the newer uses of progestins. Dr. Goldfarb is on the faculty at Jefferson. He will be followed by the Dean of the new medical school at Rutgers. Dr. Stetten will talk about recent developments in our understanding of gout. You are invited to stay for luncheon, but the formal program will end at 1 p.m. For more details write to Dr. Emanuel Abraham at 1611 Grand Avenue in Asbury Park.

Sidney Cohn, M.D.

Paul Grossbard, M.D.

Passaic

Heterotopic Pregnancy*

Coexisting intrauterine and abdominal or tubal pregnancy is exquisitely rare. Coexisting uterine and ovarian pregnancy has only once before been reported in the world's literature.

Coexisting intrauterine and extrauterine pregnancy (heterotopic pregnancy) is rare. Devoe and Pratt [1] estimate that it occurs in one out of every 30,000 pregnancies. Further studies have been made by Zarou and Sy,[2] and by Winer and his associates.[3]

Winer, Bergman, and Fields [3] have reviewed the world literature through 1954, and (including their own three cases) compiled a total of 466 cases of heterotopic pregnancy. Subsequent reports have added 38 more cases,[4 to 13] thereby increasing the number of reported cases of concomitant intra- and extrauterine gestation to 504, as of December 31, 1961.

The present case is only the second of its kind. The only other established intrauterine and ovarian pregnancy found in the literature was that reported by Rannels.[14]

The patient was a 33-year old gravida 3, para 2. Her first pregnancy terminated in 1955 *via* spontaneous abortion, requiring curettage. In 1957 she had a normal pregnancy, with delivery of a living child. In 1959 she had another normal pregnancy with vaginal delivery. Otherwise, her past history was not remarkable. The patient was Type O, Rh Negative. There had been no antibody formation in any of her previous pregnancies.

This woman was first seen on September 26, 1960, complaining of suprapubic pain, stronger on the left side than on the right. The pain was aggravated by motion, but had no relation to urination or defecation. Her last normal menstrual period had commenced on August 13, 1960. Examination at that time was not remarkable. There was some lower abdominal tenderness, but no spasm, guarding, or rebound tenderness. On pelvic examination there was some bilateral adnexal tenderness, but no definite masses were felt. She was given analgesics and sent home with instructions to call back should there be any change. The pregnancy test was reported as positive. A week later, the pain was constant and stronger. Examination revealed diffuse lower abdominal tenderness, with spasm, guarding, and marked rebound tenderness. Pelvic examination was impossible because of voluntary rigidity, due to tenderness. Motion of the cervix produced intense pain.

Suspecting intraperitoneal bleeding, probably secondary to an ectopic pregnancy, the patient was hospitalized immediately. Her hemoglobin was then reported at 7.95 Grams. Otherwise, the laboratory data were not remarkable.



Section of ovary with decidual reaction of stroma and chorionic villi.

*This work is from the department of Obstetrics and Gynecology of the Beth Israel Hospital, Passaic, N. J.

†We used the Squibb brand of hydroxyprogesterone, tradenamed Delalutin®. We administer 125 milligrams a day.

In the operating room, examination under anesthesia revealed the uterus to be symmetrically enlarged, soft, and the size of a five weeks' gestation. The cervix was closed. Colpocentesis produced blood which did not clot. Laparotomy revealed 400 cubic centimeters of old and fresh blood in the peritoneal cavity. The uterus appeared gravid, and the tubes and left ovary were grossly normal. The right ovary was twice normal size, and at one pole, there was what appeared to be a ruptured corpus luteum cyst from which there was active bleeding. That portion of the ovary was resected and the abdomen closed. The patient received 500 cubic centimeters of blood, and withstood the procedure well. Postoperatively, because of the intrauterine pregnancy, she was given hydroxyprogesterone† and C.V.P. with K, two tablets three times a day. Her postoperative course was uneventful, and she was discharged on the seventh postoperative day.

The remainder of her antepartum course was normal. She was readmitted to the hospital on May 14, 1961, in the fortieth week of pregnancy, in active labor. After a three-hour labor, she spontaneously delivered a normal male child. Her postpartum course was uneventful.

Pathology report: The specimen consists of two segments of ovarian tissue, measuring together 3 by 2 by 1½ centimeters. One has the typical yellowish color of a corpus luteum, while the other segment appears dark red in color. Microscopically, the ovarian tissue showed large corpus luteum. In certain areas there is marked decidual reaction of the ovarian stroma, with adjacent chorionic villi and blood clots.

For the diagnosis of ovarian pregnancy, Spiegelberg's criteria must be fulfilled:

1. The tube, including the fimbria, must be intact and separate from the ovary.
2. The gestation sac should definitely occupy a position on or encompassing the ovary.
3. The sac must be connected with the uterus by the ovarian ligament.
4. Ovarian tissue must be demonstrable in the walls of the sac.

The findings at operation and microscopic examination support this diagnosis.

The clinical significance of heterotopic pregnancy cannot be overemphasized. Too often, during the diagnostic investigation or treatment of a patient, the finding of one situation or disease may lull the physician into a false sense of security.

162 Lexington Avenue

BIBLIOGRAPHY

1. DeVoe, R. W. and Pratt, J. H.: Amer. J. of Obstetrics and Gynecology, 56:1119 (1948).
2. Zarou, G. S. and Sy, M.: Amer. J. of Obstetrics and Gynecology, 64:1338 (1952).
3. Winer, A. E., Bergman, W. D. and Fields, C.: Amer. J. Obstetrics and Gynecology, 74:170 (1957).
4. Viviano, J. G.: Amer. J. Obstetrics and Gynecology, 72:191 (1956).
5. Vasilka, A. I. and Grable, E. E.: *Obstetric-Gynecologic Survey*, 11:603 (1956).
6. Bell, T. G.: Amer. J. Obstetrics and Gynecology, 74:1270 (1957).
7. Lawson, J. G. and Chouler, F. J.: J. of Obstetrics and Gynecology of the British Empire, 62:951 (1955).
8. Jacks, L. M.: Med. Journal of Australia, 42:536 (1955).
9. Selmeci, E. and Lakatos, G.: *Orvosi hetil.* (Budapest) 96:55 (1955).
10. deMoraes, A. and Ferrera, C.: *An. brasil ginec.*, 39:327 (1955)
11. Bertling, M. H. and Burwell, J. C.: (letter to the editor) *Obstetrics and Gynecology*, 11:591 (1958).
12. Mizbah, G.: Canadian Med. Assn. Journal, 71:36 (1959).
13. Lloyd, T. S., Jr.: Virginia Med. Monthly, 88:217 (1961).
14. Rannels, H. W.: Obstetrics and Gynecology, 2:281 (1953).

Appreciation to Dr. Allman

The Executive Offices have received a special "thank you" note from the AMA's Council on Medical Services . . . a note which " . . . expresses AMA's appreciation for the services of Dr. Allman. The Council is grateful for all that Dr. Allman is doing for medicine and wants members of The Medical Society of New Jersey to know this."

Introduction of New President*

Marcus H. Greifinger, M.D., Newark

Mr. President, Officers and members of The Medical Society of New Jersey, distinguished guests, ladies and gentlemen:

A long-enduring, genuine friendship is itself its own reward. Today I find that some times it pays dividends of honor and privilege neither anticipated nor deserved. It is because for some four decades I have enjoyed the friendship of Jerome Kaufman that now I have the honor of presenting him to this assemblage as the 171st President of The Medical Society of New Jersey. It is with heartfelt pride and pleasure that I do so.

It would be presumptuous of me to try to tell *you* anything essential about the man whom you have chosen to lead our Society for the next year. It was precisely because of your appreciation of his character and ability that you made your choice. The service that I can now render is to supply a brief biographic resumé, in order to put you in possession of the chronology of Dr. Kaufman's career development. You know the man himself; let me supply you with the schedule and outline of his progress toward the eminence which now he is to assume.

On May 30, 1901, in Newark, New Jersey, there was born to Dena and Isaac Kaufman the son Jerome G. Kaufman whom today we honor. Having completed his early schooling in Newark, he pursued his pre-medical education at Harvard and then matriculated at the University and Bellevue Hospital Medical College in New York City. From this institution, he received his Doctorate in Medicine in 1925.

By the time of his graduation, the young man had already begun his work among patients by affiliating himself as an extern at Newark City Hospital in 1923. On graduation from Bellevue he entered upon a two-year internship at Newark City Hospital.

In 1928 he entered upon a life-long contract through his marriage to Miss Maola Pross—a contract that has been rich in satisfaction and happiness for both parties.

By 1927 he knew that he wanted to specialize in internal medicine. For that purpose he associated himself with Dr. Marcus Rothschild of New York City, an association which Dr. Kaufman maintained until the death of Dr. Rothschild in 1936.

In 1936, Jerry joined the faculty of the New York Medical College (Flower Hospital Medical School) as assistant in cardiology in the department of medicine, then under the direction of Dr. Milton J. Raisbeck. At the present time, Dr. Kaufman is the assistant professor of medicine of the New York Medical College.

Since 1942, he has been active in the affairs of The Medical Society of New Jersey, reflecting a similar activity in the Essex County Medical Society. Dr. Kaufman's first committee appointment in State Society affairs was to the Committee on Cardio-Vascular Diseases, chaired at the time by the late Dr. Stanley Nichols. Out of the activity of the committee emerged the New Jersey Health Association, of which Dr. Kaufman is a charter member. As a member of the staff of Newark Beth Israel Hospital, he found time to make himself responsible for the interns' educational program, and he served later as the procurement officer for house staff officers at Beth Israel. Early in his career at Beth Israel, Jerry volunteered to make himself responsible for the health care of the nurses. As a matter of fact, he still looks after the nurses.

Beyond the connections which I have already referred to, Dr. Kaufman is now attending physician emeritus at the Newark City Hospital; attending physician and past-president of the medical staff of Newark Beth Israel Hospital; consulting cardiologist at the Essex County Hospital in Belleville; and consultant in internal medicine at the Monmouth Memorial Hospital, Fitkin Memorial Hospital, the Riverview Hospital, East Orange General Hospital, and the Kessler Institute. He is medical director of the United Order of True Sisters' Home for Cardiac Children.

A Fellow of the American College of Physicians, he is also a diplomate of the American Board of Internal Medicine. One can add to this list a long presentation of offices which Dr. Kaufman has held or still holds. They are the natural consequences of his gifts and capabilities as a dedicated physician and as a practitioner who serves and loves his fellowmen.

*Remarks made May 13, 1963 at the annual meeting.

In the making of a great doctor something more than expert knowledge and outstanding professional skills is necessary. That something comes from the heart of the man who serves. It has its roots in a sense of brotherly concern for his fellowmen. It finds expression in a sustained and genuine interest in their welfare and in an attitude of constant sympathy and compassion. Dr. Kaufman's patients find all these qualities in him, and for that reason they not only esteem him highly but they hold him in profound affection.

Through all his life, he has had the tendency to give unstintingly of himself in order that he may do the job well. The record of his successful accomplishments illustrates the effectiveness of his efforts. I know that he will conscientiously apply himself to the exactions of the high office which today he assumes. From the bottom of my heart for myself, for his friends, for his patients everywhere, and for all of you, I wish him an outstandingly successful term of office as the 171st President of The Medical Society of New Jersey . . . Ladies and gentlemen, Dr. Jerome George Kaufman.

Address of Retiring President*

Louis S. Wegryn, M.D., Elizabeth

Of the time allotted to me as president of The Medical Society of New Jersey, little now remains. Thus, the moment has come for me to take my leave of this House, and to express to all its members my profound gratefulness both for the honor of serving as the 170th president of our Society and for the cooperation and support which, throughout the year, I have uniformly enjoyed.

There are few satisfactions dearer to the human heart than the satisfaction of knowing that one's fellows approve and trust him. I have been happy, through the year now ending, in the consciousness of the approval and trust of my fellow-members of The Medical Society of New Jersey, so gratifyingly manifest in my election to office. I have striven at all times worthily and efficiently to fulfill the obligations of the presidency. I hope that my administration of the office has been a source of satisfaction to all of you.

Terms of office may end and groups of officers may come and go, but the purpose of our Society . . . "to promote the betterment of public health; and to enlighten and direct public opinion in regard to the problems of medicine and health for the best interests of the people of New Jersey" . . . remains unwaveringly constant. In consequence of movements for change in our fundamental social, political, and economic concepts, as a people and as a nation—movements for change that reflect the restless uncertainties of nations and peoples everywhere in the world today—the problems of medicine have increased, and are increasing in number and character.

As responsible members of the profession and as responsible citizens of our beloved country, we are all determined to do all that lies within our power to preserve and advance the health and vigors of our people and the health and vigors of our nation. Decisions of tremendous magnitude and awful consequence remain to be made. We accept it as our duty and our right to participate vigorously in the formation of those decisions, since they will so profoundly influence our lives as individuals and our destiny as a nation.

In this connection, addressing you last year as I entered upon my term of office, I declared:

> "The American physician of today must carry on in the high traditions of his humanitarian profession by learning and doing all things necessary for the good of his patients. He must, in a professional sense, serve and care for his patients. But over and above all this, as a citizen—for his patient's sake, for his own and his children's sake, for his country's sake—he must encourage his fellow-citizens not to surrender to government their personal independence or responsibility, but to insist instead in protecting themselves and the government from irreversible commitments that would inevitably be disastrous for them, for our country, and for the world."

Today I reaffirm that statement, and I pledge myself in whatsoever capacity it may be my privilege to serve, to do all that I can to preserve and perpetuate the ideals of service and freedom to which we have all dedicated our lives. I retire from the presidency, therefore, but not from the work that together we have been doing. I am and will be with you still, for as long as I am able to do whatever I can.

*Remarks before House of Delegates, third session, May 14, 1963.

1963 Golden Merit Awards

Following are the remarks of President Louis S. Wegryn, on the occasion of the Seventh Annual Bestowal of the Golden Merit Award on May 11, at the 197th Annual Meeting of The Medical Society of New Jersey in Atlantic City.

It is, I think, a most happy circumstance that reserves for the President of the Society, as almost his last official ceremonial act, the privilege of bestowing the Golden Merit Award of The Medical Society of New Jersey upon its distinguished and beloved recipients.

Nothing that I have been privileged to do as President of this Society has given me such profound gratification and pleasure as this act of mine today, in offering deserved homage and thanks to you, my colleagues, for your long and illustrious lives of deep devotion and splendid service.

Such honor and fame as the profession of Medicine has enjoyed in the last fifty years and can claim as its own today, it owes to men and women like you, who, in pursuit of the idealistic visions of their youth, worked to accumulate the treasured memories, the satisfactions of soul, and the deserved tributes of love and respect which are yours today.

Of late, much thought and effort have been expended in the attempt to ascertain how contemporary Medicine can preserve and improve the public image of the doctor. The implication is that that image has lost some of its lustre, that it is not as distinguished as it once was.

All this is an unconscious tribute to men and women like you, distinguished colleagues, because the image of excellence which we are trying to preserve today is the image which you, by the scope of your skills and the nobility of your lives, have all unconsciously created.

You have built better than you know. It remains for us, and for all who follow—if we are sincere in our desire to be admired, respected, and loved—to pattern ourselves upon you and to try to be, in turn, men and women of your stamp and character.

Thank you for giving so much of yourselves, with such noble and prodigal generosity, to your profession and to your fellowmen. Since we know, on the highest authority, that it is much more blest to give than to receive, you are deservedly among the most blest, the happiest, of people. God keep you so—not only for the many golden years you are yet to enjoy on earth, but always.

Recipients of the Golden Merit Award

ATLANTIC COUNTY

Norman James Quinn, M.D., 5700 Atlantic Avenue, Ventnor

Charles Hendry deTurck Shivers, M.D., 121 South Illinois Avenue, Atlantic City

BERGEN COUNTY

John Duane Dickson, M.D., 202 Larch Avenue, Bogota

Christian Peter Segard, M.D., 1106 Roycott Way, San Jose, California

BURLINGTON COUNTY

Jacob Segal, M.D., 509 West Cherry Hill Apartments, Cherry Hill

Charles Francis Voorhis, M.D., 330 Morgan Avenue, Palmyra

CAMDEN COUNTY

Cedric Eugene Filkins, M.D., 412 White Horse Pike, Audubon

CUMBERLAND COUNTY

Ada Harris Walker, M.D., 4 Columbia Avenue, Vineland

ESSEX COUNTY

Sanel Beer, M.D., 1459 N. W. South River Drive, Miami, Florida

Harry Cherashore, M.D., 363 Centre Street, Nutley

LeRoy Lorenzo Colsh, M.D., 625 Lake Avenue, Bay Head

J. Wallace Hurff, M.D., 671 Broad Street, Newark

John Earl Kiley, M.D., 94 Park Street, Montclair

Harry A. Lowenstein, M.D., 15 Wilbur Avenue, Newark

Royal Albert Schaaf, M.D., R.D., Califon

Joseph Albert Schramm, M.D., 191 Littleton Avenue, Newark

GLOUCESTER COUNTY

Chester Isaac Ulmer, M.D., Evergreen and Red Bank Avenues, Woodbury

HUDSON COUNTY

Thomas William Connolly, M.D., 305 Monmouth Avenue, Spring Lake

MIDDLESEX COUNTY

Benjamin F. Slobodien, M.D., 233 High Street, Perth Amboy

John Francis Weber, M.D., 4 Sturbridge Road, Wellesley Hills, Massachusetts

MONMOUTH COUNTY

Max M. Jarecki, M.D., 905 Bergh Street, Asbury Park

MORRIS COUNTY

Alvan Spencer, M.D., 26 St. Mary's Place, Denville

PASSAIC COUNTY

John Howe Carlisle, M.D., 199 Aycrigg Avenue, Passaic

Isidor Cohn, M.D., 231 Lexington Avenue, Passaic

Thomas J. E. Holmes, M.D., 151 Fair Street, Paterson

Friedrich Rothenberg, M.D., 155 Hazel Street, Clifton

Louis Gershon Shapiro, M.D., 375 Broadway, Paterson

Elroy Willis Smith, M.D. 19 Country Club Drive, Charleston, South Carolina

UNION COUNTY

Z. Lawrence Griesemer, M.D., 230 West Jersey Street, Elizabeth

Trustees Minutes: April 21, 1963

A regular meeting of the Board of Trustees was held on Sunday, April 21, 1963, at the Executive Offices. For the full information of the membership, detailed minutes are on file with the secretary of each component society. A summary of the significant actions follows:

Medical Assistants Association . . . Approved the formation of a New Jersey State Chapter of the National Association of Medical Assistants.

Dr. David Allman . . . Received a letter of recognition of Doctor Allman's services on the AMA Council on Medical Service.

Medicare Program . . . Authorized the signing of the new contract for 1963-64.

Intern Approval Program . . . Drew up the following two resolutions for presentation to the House of Delegates—with copies to 49 other state delegations:

RESOLUTION ONE

Whereas, acting upon supplementary report D of the Council on Medical Education and Hospitals, the House of Delegates—meeting in Los Angeles in November, 1962—adopted the following statement:

"In order to maintain high standards of education and better assure the patients' welfare, at least 25 per cent of the total house staff (interns and residents) of a hospital should be graduates of accredited United States or Canadian medical schools. When United States and Canadian graduates represent a lesser portion of the house staff for two successive years, this will warrant that serious consideration be given to disapproving the internship"; and

Whereas, previously the standards for granting approval to a house staff training program had been exclusively concerned with the educational qualifications of the candidates and with the educational quality of the training program offered; and

Whereas, previously candidates qualified themselves as acceptable either as graduates of an approved American or Canadian medical school or as graduates of a foreign medical school who have successfully passed the examination given by the Educational Council for Foreign Medical Graduates; and

Whereas, by its action the House added a new standard for determining the acceptability of a candidate for admission to an approved program, a standard utterly unrelated to his educational competence—namely, consideration of the geographical area in which the candidate pursued the studies leading to his M.D. degree; and

Whereas, by its action the House would deny to graduates of foreign medical schools who fully satisfy all proper educational requirements the opportunity to serve as interns in any hospital already having 75 per cent of qualified graduates of foreign schools on its house staff roster by threatening to disaccredit such hospital if it grants further acceptances; and

Whereas, such denial of the candidate's right to a place on the House Staff merely because of his geographical backgrounds would be indefensibly discriminatory, and would contravene the obligation of the medical profession of the United States —as the Council on Medical Education and Hospitals in its report so eloquently points out—". . . to play a key role in furthering one of the objectives of the Exchange-Visitor Program . . . to increase mutual understanding between the people of the United States and the people of other countries"; and

Whereas, such denial would manifestly do a deep disservice to the fair name of American Medicine and to our country's international relations; now therefore be it

RESOLVED, that the House of Delegates of the American Medical Association rescind that action taken in Los Angeles and re-establish educational and qualitative standards as the exclusive criteria governing the operation of, and admission to, approved intern and resident training programs in all hospitals, affiliated or non-affiliated, in the United States.

RESOLUTION TWO

Whereas, in supplementary report D—submitted by the Council on Medical Education and Hospitals to the House of Delegates at the Los Angeles meeting, in November 1962—the Council declared:

> "It is noted with particular concern that some hospitals with full rosters of graduates of North American medical schools fail to accept reasonable complements of well-qualified foreign graduates into their internship programs annually. If our obligations are to be met, it is important that these hospitals provide opportunities for an adequate proportion of such graduates"; and

Whereas, as the Council also declared in that report, it is the heavy obligation of the medical profession of the United States in furtherance of one of the objectives of the Exchange-Visitor Program . . . "to increase mutual understanding between the people of the United States and the people of other countries"; and

Whereas, the failure of certain hospitals to accept "reasonable complements of well-qualified foreign graduates into their internship programs annually" is in basic disregard of this heavy obligation of the medical profession and is destructive of the cited objective of the Exchange-Visitor Program; now therefore be it

RESOLVED, that this House adopt the following as its official policy:

> "When United States and Canadian graduates represent a greater proportion than 75 per cent of the house staff of any hospital for two successive years, this will warrant that serious consideration be given to disapproving the internship and/or resident training program of every such hospital."

Foreign Interns and Residents . . . Authorized a questionnaire to hospital administrators, chiefs of staff, and directors of medical education or chairmen of medical intern programs, to obtain information and statistics on the problem of foreign interns and residents.

Cancer Control Committee . . . Approved the report of the Cancer Control Committee that its scope and effectiveness might be enhanced "if cooperation were continued with the Medical Committee of the New Jersey Division of the American Cancer Society."

1963 Eye Health Screening Program . . . Approved the 7th Annual Eye Health Screening Program, to be held September 23 through September 28, 1963.

Mental Health Committee . . . Approved the following recommendations of the committee:

(1) That county mental health chairmen meet with their local committees and organize small mental health congresses within their county, to which would be invited representatives from other county committees and organizations.

(2) That each county committee appraise the services, co-ordinate and integrate information available from existing studies, and discuss problems and needs of their community and possible future plans.

(3) That the chairmen of county mental health committees reconvene in conjunction with the 1963 annual meeting in Atlantic City, to digest reports from counties and make appropriate determinations as necessary.

Emergency Medical Identification . . . Concurred in the action of the AMA in favoring the principles involved in the Medic-Alert Foundation and in encouraging the use of emergency medical identification devices, without officially evaluating or endorsing any particular device or program.

AMA Meeting Hospitality Room . . . Authorized a New Jersey Hospitality Room at the AMA Meeting in Atlantic City, June 16 through June 19.

Compensation of Interns and Residents . . . Directed that New Jersey's resolution on compensation of interns and residents, which was withdrawn at the AMA Clinical Session in Los Angeles, be submitted to the AMA for re-introduction at the forthcoming AMA Meeting.

Book Reviews

The Science of Dreams. By Edwin Diamond. Garden City, N. Y., 1962, Doubleday. Pp. 265 ($4.50)

Most physicians—other than psychiatrists—consider dreams to be of physiologic, rather than psychologic origin. Recent work has shown that during dreaming, enough brain changes occur to produce visible alterations in the electro-encephalogram. Mr. Diamond, an editor of *Newsweek*, here reports on research into the sleeping physiology of the brain, which supports the general medical (non-Freudian) concept of dreams. Since the work uses kymographs, electro-encephalograms, and electronic equipment, it is, Mr. Diamond, suggests, a true science; hence the title of the book. Dreams are alleged to be essential to peace of mind. They provide the reticular formation of the brain with the stimulation necessary to keep it in good order. Mr. Diamond says that everybody dreams every night—indeed produces three to five dreams a night; well over a thousand a year. The book does not include any effort to "interpret" dreams either in the psychoanalytic or in the Gypsy Dream Book sense. Although the word "dream" usually has connotations of the pleasant and desirable (the dream girl, for instance), Mr. Diamond finds that unpleasant dreams are more numerous than pleasant ones. And, if it's any consolation, the ratio of unpleasant dreams rises as one grows older.

HERBERT BOEHM, M.D.

Medical Jurisprudence and Toxicology. John Glaister, M.D. Baltimore, 1962. Williams and Wilkins. Ed. 11. Pp. 720, with 235 illustrations. ($11.00)

For 60 years this book and its predecessor volume have been serving British and Scottish physicians. More than 200 pages are now devoted to toxicology with emphasis on testing for poisons. The detailed descriptions of poison testing procedures are extremely valuable to anyone who has had occasion to do the work. In addition to the toxicology section, the book falls into two parts. One deals with forensic medicine, the other with medical jurisprudence. The latter—describing evidence, discussing privileged communications, malpractice (they call it *malpraxis*) and reciting statutes is of limited value to American readers since it concerns only British legal procedures. However, the rest of this section is a useful handbook of forensic medicine. It covers causes of death, diagnosis of coma, identification, and the like. This book has already been accoladed by two generations of medical practitioners. Any additional bouquet would seem to be unnecessary.

ULYSSES M. FRANK, M.D.

Psychophysical Methods for Relief of Childbirth Pain. C. Lee Buxton, M.D. Philadelphia, 1962. W. B. Saunders Company. Pp. 116. ($4.75)

Upon returning from a very busy and productive sabbatical, Dr. Buxton has presented to us a brief (116 pages) but intensely interesting account of his findings. There is real need for a book of this type. For some time now, obstetricians have been aware of a growing movement among their colleagues, and among the laity, to add some sort of psychophysical aspect to normal prenatal routine. This demand has been met only fitfully and in scattered areas of the country, possibly because the technics involved have been poorly understood.

Dr. Buxton has managed to bring some order out of the chaos and to present his findings in such a lucid, dispassionate, and non-crusading way that even the most biased could find little fault with his reporting. This pattern of pure objectivity is one of the most rewarding features of this book.

The section on the use of highly trained midwives in Europe may be a brief glimpse into the future here if our population growth continues to exceed the supply of obstetricians. This manual is highly recommended reading for anyone involved with the parturient.

PERCY L. SMITH, M.D.

An Atlas of Head and Neck Surgery. By John M. Lore, M.D. Philadelphia, 1962, W. B. Saunders. Pp. 490. Illus. ($25.00)

The jurisdictional dispute which has involved those who practice head and neck surgery receives immediate recognition in the opening pages of Dr. Lore's book. In his preface he bespeaks the need for contributions from the many surgical subspecialties implicated in this field; and in his brief remarks, Dr. Hayes Martin carries the torch, as he has always done, for the general surgeon. Dr. Lore pleads for a reunion of the surgical specialties with general surgery to establish a broader training program in head and neck surgery, an eventuality which will probably be long in coming.

Perhaps in tune with his thinking along these lines, the author has included many procedures not ordinarily thought of in connection with head and neck surgery, which has primarily concerned itself with the management of neoplastic disease. It seems a bit strange, therefore, to encounter descriptions and illustrations of operations one ordinarily finds in otolaryngologic texts—such as nasal polypectomy or submucous resection—or in textbooks of plastic surgery—such as cleft palate repair and rhinoplasty. The scope of the work becomes, as a result, almost encyclopedic; as a

reference for residents training in this field it will have great value. The illustrations are clear and well-executed, if at times diagrammatic and a little over-simplified.

As in any book, one finds statements with which one does not agree. Dr. Lore warns against the biopsy of any primary parotid tumor, "since such procedures almost guarantee recurrences." This reviewer has aspirated dozens of such tumors and has yet to see a recurrence from this procedure. Again he takes a stand against delivery of a substernal thyroid into the neck lest injury to the recurrent nerves of the lowermost thyroid veins occur. Many a competent surgeon will testify to the ease and safety with which this can be done, excluding, of course, those instances of substernal extension of carcinoma.

Of particular interest is the chapter on vascular surgery in the head and neck. Dr. Lore's qualifications in this area make this one of the best parts of the book and a welcome addition to the store of knowledge needed by those entering this field.

W. Franklin Keim, M.D.

They Took to the Waters: The Forgotten Mineral Spring Resorts of New Jersey and Nearby Pennsylvania and Delaware. By Harry B. Weiss and Howard R. Kemble. Trenton, New Jersey, 1962, The Past Times Press. Pp. 232. 53 illus. ($6.00)

This interesting book chronicles a vanished era in America—the mineral water age—an epoch recalled today by the British 'Spa' and Continental 'Bad' and 'Bain' culture of Europe. The spring water resorts of New Jersey, Pennsylvania, and Delaware described in this volume flourished during the eighteenth and nineteenth centuries under the patronage of leading physicians. An attempted rebirth of the American spa vogue in the present century, promoted by Drs. Simon Baruch and Henry Sigerist, among others, met with little response from public or medical profession. The relaxing pilgrimage to "take the waters" had passed from the American scene.

Mineral spring resorts, of which over 75 flourished in the Middle Atlantic States, catered to the ailing—and hale—for over 150 years. The period of bathing and drinking at these 'medicinal' springs was followed by one during which bottled waters were consumed in homes and restaurants. Some of the spring resorts dated from Colonial times: in New Jersey, Tinton Falls (1749), Schooley's Mountain (1763), and Woodbridge Spa (1772); in Pennsylvania, Bristol Chalybeate Baths (1700), Yellow Springs of Chester County (1722), Abington Waters (1768), Philadelphia, and Harrowgate (1773). The peak of the spring water resortage came in the nineteenth century, with a steady decline near the turn of the twentieth century—in part a reflection of improved municipal water supplies.

The resort hotels, persons and social life met during these years are readably narrated in this book, one which documents a previously neglected phase of life in America. Detailed information is given on the location and composition of the mineral waters, the amenities afforded by the resorts, and the rise and fall of fads. *They Took to the Waters* is a valuable contribution to Americana, and makes good reading for all. It captures in vivid style some charm from a less hurried age. There are nineteen chapters, in which the various mineral springs are described according to county location, three appendices, and an index in the book.

Fred B. Rogers, M.D.

Clinical Obstetrics. By Benjamin Tenney, M.D. and Brian Little, M.D. Pp. 424. Illus. ($8.50)

The authors have succeeded in transmitting in 424 pages of good English and only the minimum of illustrations, their ideas of how to practice obstetrics. In the preface they make a strong point: that if you teach one good method of handling a situation even though other methods may be just as efficacious, the practitioner may then use his own experience as a basis for adjustment.

The common-sense appraisal of the use of all necessary roentgenographic procedures during pregnancy is most valuable. So also is their recommendation for careful thought before giving medication to a woman in labor, particularly premature labor.

There is not much in this book with which one may disagree, but I cannot accept the statement that analgesic drugs administered early in labor may halt labor, if one accepts the definition of labor as "regular contractions less than 10 minutes apart, each lasting at least 40 seconds with progressive dilatation of the cervix."

Aaron Lowenstein, M.D.

Drug Therapy. Frank C. Ferguson, M.D. Philadelphia, 1962, Lea & Febiger. Pp. 411. ($7.50)

Small enough to be portable, flexible in binding, compact in text, this little volume offers quick reference to drugs, their usage, dosage and available forms. While generic names are used, trade names appear in a cross-index. The general arrangement is by drug groups (anesthetics, autonomic nervous system, blood and so on) rather than by indications. In some respects it is like a hospital formulary and, like such a formulary, it is a practical working tool, and not a treatise on pharmacology.

Victor Huberman, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

JUNE, 1963 • VOL. XXXVI, NO.6

FRONTIERS IN MEASLES PROPHYLAXIS

A vaccine made from an attenuated strain of virus has proved 100 per cent effective in protecting vaccinated children from developing measles in trials conducted to date. Electroencephalographic records of 28 vaccinated children have revealed no abnormalities.

Before embarking on a discussion of results attained to date with various measles vaccines, it seems proper to determine what the extent of morbidity and mortality of this disease may be in our country. During the period from 1950 to 1959, nearly 5.5 million cases of measles were reported, according to the United States Public Health Service. Since reported cases represent only 25 per cent of those actually occurring, we can estimate that there were 22 million cases during this period, or 2 million a year.

While in the United States the mortality reported due to measles averages only about 500 to 600 a year, there are no valid statistics on the incidence of bacterial or of central nervous system complications. However, based on an estimated occurrence of encephalitis of 1 per 1,000 cases of measles, there would have been more than 5,000 instances of encephalitis among the 5 million reported cases, or 22,000 among the 22 million cases believed to have occurred during the same 10-year period.

LIVE-VIRUS VACCINE

At the present time there are two avenues of investigation in measles prophylaxis. The first involves the use of living agents which have been attenuated and the second involves the use of killed or inactivated viruses that have been grown in monkey-kidney cell cultures. In our laboratory we have been working with attenuated strains. Our hope has been that a single administration of an attenuated agent would be sufficient to provide the same lifelong immunity afforded by a single episode of the natural disease. The results to be reported have been achieved with a preparation of Edmonston virus grown in chick embryo tissue culture.

After a single subcutaneous, intradermal, or intramuscular injection of this material, a modified illness resulted resembling natural measles which has been attenuated by administration of gamma globulin.

MINIMAL DISABILITY

More than 80 per cent of susceptible children inoculated with attenuated virus vaccine developed a fever greater than 100 degrees by rectum one week after the injection. This lasted two to three days and reached an average maximum of 102.4F. Despite this febrile response, there was minimal disability noted by the children or their parents.

In nearly half of the children physicians saw a fleeting rash develop approximately 10 to 11 days after administration of the vaccine. This usually was confined to discrete macular lesions on the neck, behind the ears, or on the cheeks.

Children receiving the attenuated virus do not develop the typical catarrhal symptoms of measles; that is, cough, coryza, and conjunctivitis, although a few had mild conjunctival

Samuel L. Katz, M.D., *New York State Journal of Medicine*, February 1, 1963.

infection. The children have remained up and about, in many instances have continued at school. The total duration of clinical response to the attenuated virus varies between two to four days, as opposed to the average of more than seven days in the natural disease. To date, no child receiving attenuated vaccines has developed a bacterial complication. The large question remaining, of course, relates to central nervous system complications. More than 10,000 children have received attenuated live-virus vaccination, and there has been no indication of central nervous system involvement. Of course, more cases are needed to establish statistical reliability.

EFFECTIVENESS OF VACCINE

In the trials conducted to date, children known to be susceptible have been left in intimate contact with their vaccinated colleagues. None of these susceptible children has come down with a secondary response or developed antibodies indicative of this, which is in contrast to children with natural disease. Ninety-six per cent of 284 susceptible children from whom both pre- and post-inoculation serum specimens were available showed a four-fold or greater rise in antibodies to measles virus. The geometric mean titers of both complement-fixing and neutralizing antibodies have remained indistinguishable for more than four years from those of children after natural measles. These results suggest that such antibody levels will persist indefinitely and provide a lifelong immunity equal to that afforded by the natural disease.

The most important question is the prophylactic efficacy of the vaccine. To date, we have had experience with 84 children who at varying intervals ranging from two to 16 months after vaccination have been intimately exposed to the natural disease. There has been 100 per cent protection of the vaccinated children, as contrasted to measles attack rates of 70 to 100 per cent in control, unvaccinated susceptible children.

The question of central nervous system involvement with measles is a prominent one which cannot be answered completely at this time. Electroencephalographic tracings were made after vaccination of 37 children. The records of 28 susceptibles showed no abnormalities whatsoever except for a single instance of a child who had a concurrent streptococcic pharyngitis resulting in a single abnormal tracing consistent with that seen in nonspecific infection. This experience, coupled with our inability to find dissemination of the vaccine virus or microscopic abnormalities when it was inoculated directly into the spinal fluid and cerebral hemispheres of measles-susceptible monkeys, has led us to be cautiously optimistic that measles encephalitis will not occur after attenuated strains of virus have been administered.

Several groups known to show unusual responses to natural measles infection have been studied. These include patients with tuberculosis, cystic fibrosis, or malnutrition, and adults. No adverse effect of the attenuated virus on the basic disease has been found. This is in marked contrast to the deleterious effects of natural measles on tuberculosis patients.

Experience over the past two and a half years with the use of an attenuated live-virus vaccine has been encouraging, leading us to believe that the widespread use of such a vaccine for the prevention of measles is near at hand.

NEW JERSEY TUBERCULOSIS AND HEALTH ASSOCIATION
15 EAST KINNEY STREET, NEWARK 2, NEW JERSEY

IN DIARRHEAS



Patient: W. O. **Age:** 45 **Sex:** F **Weight** 96

Diagnosis: Functional diarrhea

Results: Definite **Side Effects:** None

Comment: Patient has been on R-1132 (Lomotil) for fifteen months with definite improvement.

ACUTE

RECURRENT

CHRONIC

LOMOTIL® ANTIDIARRHEAL TABLETS/LIQUID

brand of Diphenoxylate Hydrochloride with Atropine Sulfate

PROMPT · SAFE · EFFICIENT

LOMOTIL directly controls the *mechanism* of diarrhea. Therefore, it acts to give symptomatic relief in all diarrheas.

Lomotil promptly arrests acute diarrhea and controls chronic or refractory diarrhea with a high degree of safety.

Pharmacologic considerations indicate that Lomotil acts on the smooth muscle of the intestines and thus lowers the excessive propulsive motility responsible for increased fluidity and frequency of stools. This localized action makes Lomotil unusually free of secondary effects.

By reducing excess propulsive motility, Lomotil assures safe, selective symptomatic control of virtually all diarrheas.

Dosage: For adults the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily. Lomotil maintenance dosage may be as low as two tablets daily.

Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. Recommended dosage schedules should not be exceeded.

Note: Lomotil is an exempt preparation under Federal narcotic statutes.

Detailed information and directions for use in children and adults are available in Physicians' Product Brochure No. 81. G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

G. D. SEARLE & CO.

Research in the Service of Medicine

"Prescribe with Confidence"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR
FOR MEN - WOMEN - CHILDREN



SOLD ON Rx ONLY
OUTFLAIR SHOES
FOR CLUB FEET

177A JEFFERSON AVE.
PASSAIC, N. J.

69 WESTWOOD AVE.
WESTWOOD, N. J.

350 MAIN ST.
HACKENSACK, N. J.

Dennis Brown Splints — in all sizes — carried in stock

FAIR OAKS HOSPITAL

SUMMIT, NEW JERSEY

CRestview 7-0143

OSCAR ROZETT, M.D.
Medical Director

MOLLIE KENNEDY, R.N.
Director, Nursing Service

EDWARD R. DUTY, M.D.
Clinical Director

N. M. JANI, M.D.
S. D. ESTRADA, M.D.
Associate Psychiatrists

THOMAS P. PROUT, JR.,
Administrator

AN 85 BED INTENSIVE TREATMENT PSYCHIATRIC UNIT

Certified by
The Joint Commission on Accreditation of Hospitals
The Central Inspection Board, American Psychiatric Assn.









VERMONT'S
MOST SCENIC RESORT

IN AN
EARLY AMERICAN SETTING
PRIVATE COTTAGES • COLONIAL INN
AND COUNTRY CLUB

★

Secluded Lakeside Location Borders
Green Mt. National Forest—
Features 9 New Holes of Golf for 1963

Rates: $14 to $21 daily, includes meals at the Inn or "dine out" privileges. Ask for full color brochure.

Some housekeeping cottages available at weekly rates
Limited number of lakeside, lakeview
and fairway residential properties available

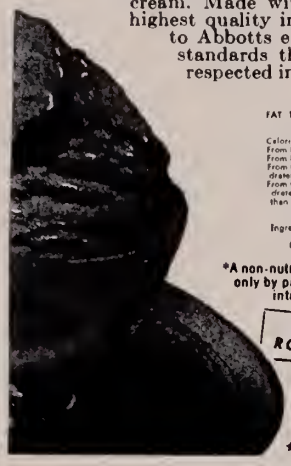


MOUNTAIN TOP *Inn*
COTTAGES AND CLUB
Chittenden, Vt. – 10 miles from Rutland
New York Office: LO 5-1114

***NOW!* DIABETICS CAN ENJOY**
(UNDER MEDICAL ADVICE)

Abbotts
ARTIFICIALLY SWEETENED
ICE CREAM

Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards—standards that are most highly respected in the dairy industry.



COMPOSITION
FAT 10.52% PROTEIN 3.71%
CARBOHYDRATES 20.40%

	Cals.	Oz. Avoir.	Oz. Fluid
Calories — Per 100 Gm.			
From Fat	94.68	26.84	16.25
From Protein	14.84	4.21	2.55
From Carbohydrates as Lactose	20.24	5.74	3.47
From Carbohydrates other than Lactose	61.66	17.48	10.58
	191.42	54.27	32.85

Ingredients: Cream, Milk, Sorbitol, Stabilizer and 0.11% Cyclamate Calcium*

***A non-nutritive artificial sweetener for use only by persons who must restrict their intake of ordinary sweets.**

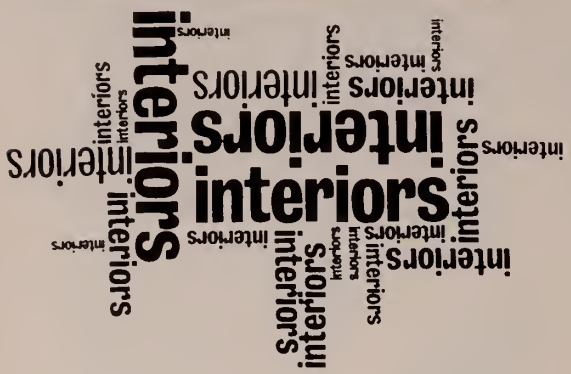
IN HANDY ROUND PINTS

At Abbotts
and Jane Logan Dealers
Abbotts Dairies



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK
Coca-Cola
TRADE MARK ®



planned by professionals . . .
for professionals . . .
with dignity and fine taste

You are invited to visit our extensive showrooms and to discuss your plan with a member of our design staff.

- interior designs
- space planning
- office furniture
- equipment
- accessories

the w.b. wood company

43 clinton street newark, n. j.
market 3-7900

WHO PAYS THE OFFICE RENT?

And telephone bill...and utilities...and employee salaries...*if YOU are sick or injured?*

Physicians Mutual Insurance Company (The Doctors' Company) will help pay all of your usual office expenses when you are sick or disabled—if you are the fortunate owner of our new, low-rate Office Overhead Expense Policy.

Premiums are tax deductible, too!

Write today for free information . . without obligation.

PHYSICIANS MUTUAL INSURANCE COMPANY
115 South 42nd St. Omaha 31, Nebraska

How Lyons Institute Serves the Medical Profession

For the past eleven years Lyons Institute of Medical, Dental and X-ray Technology has been training high school graduates to serve the medical profession as:

MEDICAL TECHNOLOGIST • MEDICAL TECHNICIAN • MEDICAL ASSISTANT
X-RAY TECHNICIAN • MEDICAL SECRETARY

Many hundreds of our graduates are employed by physicians, hospitals, clinics, laboratories, pharmaceutical concerns and private industry. If you are seeking qualified personnel in any one of the above fields, our free Placement Bureau is at your Service.

LYONS INSTITUTE of MEDICAL, DENTAL & X-RAY TECHNOLOGY
900 BROAD STREET, NEWARK 2, N. J. **Telephone: Mitchell 2-3420**
Director, CRAIG R. GARTH, Captain, U.S. Navy (Ret.)
Approved by the New Jersey State Department of Education

CHANGE OF ADDRESS

In the event of a change of address or failure to receive THE JOURNAL regularly fill out this coupon and mail at once to

THE MEDICAL SOCIETY OF NEW JERSEY, P. O. Box 904, Trenton 5, N. J.

Change my address on mailing list

From _____

To _____

Date _____ Signed _____ M.D.

LONG TERM AUTO LEASING

. . . A SERVICE ESPECIALLY PLANNED FOR DOCTORS!

M.D. PLATES FREE, TOO!

AAL LONG TERM SINGLE CAR AND FLEET RENTALS

Call ORange 6-7137 or

MAIL COUPON TODAY

lease a brand new Cadillac or other fine car from American and you'll never **buy** again. Save money, time and trouble. One modest monthly payment takes care of everything . . . insurance, maintenance, repairs, depreciation . . . and the payments are 100% tax deductible! Borrow a car—**free** of charge—in case of accident or breakdown.

INCLUDES

- Registration and plates
- Full maintenance
- Insurance

Liability $250/$500,000
Property damage $20,000
Deductible collision,
fire and theft

AMERICAN AUTO LEASING COMPANY
120 Halsted St., East Orange, N. J.
Please send me the AAL Long Term Leasing Plan.

Wide Selection of '63 Models

Special requirements _____

_____

Name _____

Address _____

City _____ State _____

ALL YOU BUY IS GAS AND OIL

ASK FOR BROCHURE

AAL

AMERICAN AUTO LEASING COMPANY

120 Halsted Street, East Orange, New Jersey • ORange 6-7137

Ranch Type - Luxurious **THE PARKWAY NURSING HOME, INC.**



1201 PARKWAY AVE.
Trenton, N. J.
882-6900

No Steps!
New audio-visual intercom system from every patient to Nurses.

One of New Jersey's newest, most modern and completely equipped Nursing and Convalescent Homes, catering to the Convalescent, Aged, and Chronically Ill.

Referring physician has full medical privileges
Complete 24-hour general nursing care
Physical rehabilitation department
Beauty parlor — air-conditioned dining room, lounge, and lobby — spacious patios

Ultra modern interiors with artistic color scheme
Stainless steel kitchen tiled to ceiling
Special diets — planned social and recreational activities

Residential Section
Reasonable Rates

The Parkway Nursing Home

NEW JERSEY STATE LICENSED

MEMBER OF AMERICAN NURSING HOME ASSOCIATION

CLASSIFIED ADVERTISEMENTS

Send replies to box number, c/o THE JOURNAL
P. O. Box 904, Trenton 5, New Jersey

$5 for 25 words or less; additionl words 10c each
Payable in advance of publication

Forms close 15th of the preceding month.

PSYCHIATRISTS—Part-time, diagnostic interviewing, individual and group therapy. Flexible schedule, supervision available. Private center. Bergen County. Write: Medical Director, New Jersey Center for Psychotherapy, 14 North Dean Street, Englewood, New Jersey; or phone LO 9-0889.

STAFF PHYSICIANS—For JCAH approved county chest disease hospital; must have New Jersey license. Salaray open, fringe benefits, maintenance at nominal cost. Contact Irving Ocheret, M.D., Superintendent, Essex County Sanatorium, Verona, New Jersey.

WANTED—Obstetrics-Gynecology opportunity. Prefer association or group practice; would accept solo practice in community needing specialist. Age 31. Married. University trained. Service obligation completed. Available August. Eugene N. Schwartzman, M.D., 9122-950 Avenue East, Oak Harbor, Washington.

YOUNG INTERNIST—Gastroenterologist. University-trained, board eligible. Desires association with another internist or small group. Training includes gastrointestinal radiology. Write Box No. 61, c/o THE JOURNAL.

ANESTHESIOLOGIST—Fellow and diplomate, desires to relocate in large or small hospital as departmental head. Will consider solo or group. Write Box 55, c/o THE JOURNAL.

OPPORTUNITY KNOCKS—Doctor leaving state for specialty training. General medical practice, medical equipment, home and office on Park Street in Upper Montclair. Pretty dutch colonial home with suite of offices attached. All the conveniences of good living and of being together. The office faces a beautiful lawn and a different street. All are bathed in winter sunshine. Walter Johnson Company, Realtors, 192 Bellevue Avenue, Upper Montclair, New Jersey, PI 6-4416 now or anytime.

RADIOLOGICAL PRACTICE FOR SALE—Paterson, New Jersey, for the cost of office building, diagnostic, and therapy equipment, lead-lined rooms; two tenants' rentals more than enough to cover taxes and other expenses. Reasonable terms. Would rent, also. Write Box 49, c/o THE JOURNAL.

GENERAL PRACTICE—Large, active, all-year-around, seashore resort. No obstetrics. Retiring in the fall. Will introducc. No down payment, liberal terms. Give complete personal details and references in first letter. Reply Box 65, c/o THE JOURNAL.

PRACTICE FOR SALE—25-year-old practice for internist or general practitioner in Monmouth County, New Jersey; beautiful 5-year-old brick home and large 5½ room office; including 200 Ma. x-ray, all new equipment, air-conditioned. Sudden death of physician. Gross well over $50,000. Financing arranged or salary basis. H. M. Swartz, M.D., 138 Cherry Tree Farm Road, Middletown, New Jersey. OS 1-3313.

GENERAL PRACTICE—For position in progressive medical group in lakes area. Locum tenens for summer leading to permanent association. Minimum $1,000/month. Start June 20. Community Medical Group, West Main Street, Boonton, New Jersey.

PHYSICIANS WANTED—Male and female, licensed, for children's camps, July-August. Good salary, free placement. 350 member camps. Department p, Association Private Camps, 55 West 42nd Street, New York 36, New York.

POSITION WANTED—Medical assistants and secretaries. Laboratory and x-ray techs. Well-trained and highly-qualified personnel (male and female) available. Phone CH 2-2330, Ext. 17, Placement Department, or write Physician Director, Eastern School for Physicians' Aides, Department 7, 85 Fifth Avenue, New York 3, New York.

DOCTOR CALLED AWAY—Established location. Home-office combination, 6-room beautiful ranch, extra 3 lovely room apartment second floor. Doctor's office separate entrance consists of 7 small rooms. Lovely grounds. Plot about one acre. Excellent parking. Must be seen to appreciate. Muricl C. Hagen Realtor, 9 Kinderkamack Road, Park Ridge, New Jersey. 391-6688. $58,000.

WEST ESSEX MEDICAL CENTER—Suites available to specialists. Full or part-time basis. Excellent location and facilities for suburban practice. Write: Stanley S. Fieber, M.D., 588 Eagle Rock Avenue, West Orange, New Jersey; or call RE 1-0011.

STIRLING PROFESSIONAL BUILDING—Doctor needed in new 5½ room suite that is adjoining an established dentist. Can be shared. Paneled waiting room, planned plumbing, parking, heat and water supplied, moderate rent. Call MI 7-2797-M.

FOR RENT—Highly desirably located professional office is now available for moderate rent. Apply to Mr. Greenman, 2130 Millburn Avenue, Maplewood, New Jersey. ES 3-2900.

CLASSIFIED ADVERTISEMENTS

FOR SALE RUTHERFORD—New Jersey. Center of town. Excellent, long-established, general practice with Ob-Gyn specialty. Retiring because of illness. Apartment, residence, and adjoining office. Write Box No. 66, c/o THE JOURNAL.

FOR RENT—Medical offices in new modern medical-dental building in rapidly growing area in Parsippany, New Jersey. Ready for fall occupancy. Will partition to suit tenant. DE 4-8665.

OFFICE FOR RENT—Irvington, New Jersey, opposite hospital, was physician's office for over 20 years. Records of recently deceased physician available. Will rent either fully equipped or unequipped. Bus line stops at door. Phone SO 3-3663 or SO 3-0277.

FOR SALE—Newark, New Jersey. Corner home, formerly doctor's office and residence, 11 rooms. Suite of offices on first floor, including two fully-equipped laboratories and separate entrance. Contact Irving E. Kosky, Esquire, 519 Springfield Avenue, Newark, New Jersey—BI 8-7912.

FOR RENT IN MONTCLAIR—Five-room suite. Ground floor. Private entrance. Physician's office for many years. Centrally located in fine residential area. Available beginning August. PI 4-7654.

NEEDED—Two physicians in different specialties to rent new offices adjacent to two general practitioners and dentist in Brick Township. Rentals under $100 monthly. Reply Box 44, c/o THE JOURNAL.

BAY MEDICAL CENTER—Toms River, New Jersey. Space available for M.D. Excellent location. June occupancy. Fischer Boulevard and Bay Avenue. KE 1-1050.

NEW PROFESSIONAL BUILDING—Oakland, Bergen County, New Jersey. Centrally air-conditioned. Office, structural arrangements, and utilities included. Excellent parking. Call Mr. Bernstein. 391-4727.

MEDICAL ARTS BUILDING—Tenafly, Corner County Road & Central Avenue. Immediate occupancy! Modeled to suit your needs without extra charge. All maintenance services included. Elevator. Central air-conditioning. Covered on-site parking. Convenient to hospitals. 24 hour service. Call—Day: DE 3-7700; Eves: (NY) MA 1-4035.

PROFESSIONAL SUITE—New building, ultra-modern, air-conditioned, A-1 location, Linden-Roselle Line (Union County). Immediate posession. Modest rental. Milmark Agency. CH 5-2700.

TEMPLE UNIVERSITY MEDICAL CENTER

presents the 7th Annual Postgraduate Course

RECENT ADVANCES IN MEDICINE

11:00 A.M. to 4:00 P.M.

on

8 consecutive Wednesdays

from

October 16 to December 4, 1963

The course will consist of seminars, panel discussions, clinics, lectures and ward rounds considering subjects of interest to the family physician. Several distinguished out-of-state authorities will participate.

Enrollment limited. Registration fee: $50.00

FOR FURTHER INFORMATION AND CURRICULUM, WRITE TO:

Temple University Hospital, Phila. 40, Pa.
Department of Medicine

THOMAS M. DURANT, M.D.
Professor
ALBERT J. FINESTONE, M.D.
Director of Postgraduate Course

THUMBSUCKING

since infancy caused this malocclusion.



THUM TRADEMARK

THUM helped break the habit and teeth returned to normal position.

THUM discourages Nail Biting too
70¢ At Your Drug Store

OFFICE SPACE—Professional building. Jackson, New Jersey. In midst of new Brookwood development, several thousand new families. Exceptional opportunity for general practitioner or obstetrician. Will alter to suit. Boyarin Real Estate Agency, 515 Clifton Avenue, Lakewood, New Jersey. FO 3-4100.

Office Suites Available - New Medical Building
Kinnelon, New Jersey

Area in need of general practitioner, surgeon, obstetrician, pediatrician, dentist.

HENRY D. RICKER **BUTLER, NEW JERSEY — TE 8-0400**

The Morristown Rehabilitation Center

66 MORRIS STREET MORRISTOWN, NEW JERSEY

JEFFERSON 9-3000



NATHAN KAPLAN, M.D., Physiatrist
MARY E. JOHNSON, Chief Therapist

ANN G. McMANUS, R.N.
Director of Nursing Service

AUDREY E. TAHLMORE
Administrator

A 38-bed rehabilitation unit specializing in orthopedic and neurological disabilities. Speech therapy, Occupational therapy and psychological evaluation available.

- - - - - -

AMERICAN HOSPITAL ASSOCIATION ACCREDITATION
MEMBER NEW JERSEY LICENSED NURSING HOME ASSOCIATION

DUGAN'S

"Bakers for the Home"

New - LITE DIET BREAD

(White Bread Baked Without Shortening)

Calories per Slice 42 Calories per oz. 70

ALSO

SALT-FREE BREAD
GLUTEN AND PROTEIN BREADS
100% WHOLE WHEAT
100% Whole Wheat Crackers

New York
Connecticut
New Jersey
Pennsylvania

"At Your Door or To Your Store
It's DUGAN'S for BETTER Baked Goods"

Phone for Delivery

HUmboldt 2-6007 in Newark

(or your local phone book for branch nearest you)

THE ORANGE PUBLISHING CO., Inc.

PRINTERS

116-118 LINCOLN AVENUE

ORANGE, NEW JERSEY

Phone OR 3-0048

Academy of Medicine Library: New Acquisitions

The Library of the Academy of Medicine of New Jersey in Bloomfield, announces this selected list of recent acquisitions.

Anatomy and Physiology: Ciba Foundation Symposium on Pulmonary Structure and Function, edited by de Reuck and O'Connor, Boston, Little, Brown, 1962.

Anesthesiology: Artusio, J. F. and V. D. Mazzia. Practical anesthesiology. St. Louis, Mosby, 1962.

Biochemistry: Chepinoga, O. P. Biologic role of nucleic acids. Jerusalem, Israel Program for Scientific Translations, 1962. *Also*: Kornberg, A. Enzymatic synthesis of DNA. New York, Wiley, 1962. *Also*: Trumper, M. and Cantarow, A. Clinical biochemistry. 6th ed. Phila., Saunders, 1962.

Cancer: O'Donnell, W. E., Day, E. and Venet, L. Early detection and diagnosis of cancer. St. Louis, Mosby, 1962.

Genetics: Conference on Genetic Polymorphisms and Geographic Variations in Disease, *National Institutes of Health*, 1960. New York, Grune and Stratton, 1962. *Also*: Hamilton, W. J., Boyd, J. D. and Mossman, H. W. Human embryology; 3rd ed. Baltimore, Williams and Wilkins, 1962.

Endocrinology: Lisser, H. and Escamilla, R. F. Atlas of clinical endocrinology: 2nd ed. St. Louis, Mosby, 1962. *Also*: Williams, R. H. Textbook of endocrinology. 3rd ed. Phila., Saunders, 1962.

Internal Medicine:

American Institute of Biological Sciences, *Washington, D. C.* An annotated bibliography of influenza, January 1, 1957 to May 31, 1960.

Burch, G. E. and DePasquale, N. P. Primer of clinical measurement of blood pressure. St. Louis, Mosby, 1962.

McHardy, G. Current gastroenterology. New York, Hoeber, 1962.

Uhley, H. N. Vector electrocardiography. Phila., Lippincott, 1962.

Wallach, J. B. and Borgatta, E. F. Rheumatic heart disease. Springfield, Ill., Thomas, 1962.

Medical Jurisprudence:

Glaister, J. Medical jurisprudence and toxicology. 11th ed. Baltimore, Williams and Wilkins, 1962.

Glueck, S. Law and psychiatry: cold war or entente cordiale? Baltimore, Johns Hopkins Press, 1962.

Liebenson, H. A. and Miller, L. F. Medical and legal evaluation of disability in personal injury cases; a practical guide for doctors and lawyers. Mundelein, Ill., Callaghan, 1962.

Regan, L. J. Doctor and patient and law. 4th ed. by C. J. Stetler, and A. R. Moritz. St. Louis, Mosby, 1962.

Neurology:

Baker, A. B., ed. Clinical neurology. 2nd ed. New York, Hoeber-Harper, 1962. 4 vols.

Burgemeister, B. B. Psychologic technics in neurologic diagnosis. New York, Harper & Row, 1962.

Crosby, E. C., Humphrey, T. and Lauer, E. W. Correlative anatomy of the nervous system. New York, Macmillan, 1962.

Forster, F. M. Synopsis of neurology. St. Louis, Mosby, 1962.

Grenell, R. G. Neural physiopathology. New York, Harper & Row, 1962.

Steegman, A. T. Examination of the nervous system: a student's guide. 2nd ed. Chicago, Year Book Medical Publ., 1962.

Obstetrics and Gynecology:

Hamilton, J. A. Postpartum psychiatric problems. St. Louis, Mosby, 1962.

McLennan, C. E. Synopsis of obstetrics. 6th ed. St. Louis, Mosby, 1962.

Parsons, L. and Sommers, S. C. Gynecology. Phila., Saunders, 1962.

Reid, D. E. A textbook of obstetrics. Phila., Saunders, 1962.

Pathology:

Bray, W. E. Clinical laboratory methods. 6th ed. St. Louis, Mosby, 1962.

(This list will be concluded in a later issue.)



whatever the shape or form of allergy...

Benadryl®

(Diphenhydramine hydrochloride)

effectively relieves the symptoms of vasomot rhinitis For patients sensitive to animal danders, this age provides twofold therapeutic action to help abort an allerg attack. **Antihistaminic action:** A potent antihistaminic, breaks the cycle of allergic response, bringing relief of snee



, locrimation, nosol blockoge, ond rhinorrhea. **Antispas-odic action:** Because of its inherent atropine-like operties, the drug affords concurrent relief of bronchial asm. ***Indications:*** Allergic diseases such as hay fever, ergic rhinitis, urticoria, angioedemo, bronchial osthmo, um sickness, atopic dermatitis, contact dermatitis, gastro-estinal allergy, vasomotor rhinitis, pruritus, physical oller-s, reactions to injection of contrast medio, reactions to ropeutic preparotions, and ollergic transfusion reactions; o postoperotive nausea and vomiting, nausea of preg-ncy, motion sickness, parkinsonism ond drug-induced rapyromidal reactions, and quieting emotionally disturbed ldren. Porenterol administration is indicoted where, in the gment of the physician, prompt action is necessary and il therapy would be inadequate. ***Precautions:*** Avoid cutaneous or perivascular injection. Single parenteral dos-e greater than 100 mg. should be avoided, particularly in hypertension and cordioc disease. Persons who have become drowsy on this or other antihistomine-contoining drugs, or whose toleronce is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tronquilizers, if used with this product, should be prescribed with caution because of possible additive effect. Diphenhydramine hydrochloride has on otropine-like oction which should be considered when prescribing it. Creom (Ointment) should not be opplied to extensively denuded or weeping skin oreos. ***Supplied:*** Kapseals® of 50 mg.; Copsules of 25 mg.; Emplets® (enteric-coated tablets) of 50 mg.; in aqueous solutions: 1-cc. Ampoules, 50 mg. per cc.; 10- and 30-cc. Steri-Viols,® 10 mg. per cc. with 1:10,000 benzethonium chloride as a germicidal agent; Elixir, 10 mg. per 4 cc. with 14 per cent alcohol; 2 per cent Ointment (water-miscible bose).

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan

4563



Formerly nervous and tense, now better able to...

enjoy her family

This, in essence, is what happens when you place a patient on Librium (chlordiazepoxide HCl). Since this agent generally relieves anxiety and tension without dulling mental clarity or inducing drowsiness, most patients become better able to function normally, take an active interest in family and surroundings, meet and solve daily problems. This antianxiety agent is virtually free from extrapyramidal side effects, and does not produce or deepen depression.

DOSAGE: **Oral**—Usual adult dose in mild to moderate anxiety and tension is 5 or 10 mg, 3 or 4 times daily; in severe anxiety and tension, 20 or 25 mg, 3 or 4 times daily. **Parenteral**—To control acute conditions, the usual initial adult dose is 50 to 100 mg I.M. or I.V.; not more than 300 mg should be given during a 6-hour period. ☐ SIDE EFFECTS: **Oral**—Drowsiness and ataxia, usually dose-related, have been reported in some patients—particularly the elderly and debilitated. Paradoxical reactions, i.e., excitement, stimulation, elevation of affect and acute rage, have been reported in psychiatric patients; these reactions may be secondary to relief of anxiety and should be watched for in the early stages of therapy. Other infrequent dose-related side effects have included isolated instances of minor skin rashes, minor menstrual irregularities, nausea, constipation, increased and decreased libido. **Parenteral**—Following parenteral administration some patients may become drowsy or unsteady. The injectable form has occasionally produced mild, transitory fluctuations of blood pressure. ☐ PRECAUTIONS: **Oral**—In elderly, debilitated patients, limit dosage to smallest effective amount to preclude development of ataxia or oversedation (not more than 10 mg per day initially, to be increased gradually as needed and tolerated). Until the correct maintenance dosage is established, patients receiving this agent should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Although this agent is a valuable aid in acute and chronic alcoholism, caution patients about possible combined effects with alcohol. Caution should be exercised in administering it to addiction-prone individuals. Careful consideration should be given to the pharmacology of any agents to be employed with Librium (chlordiazepoxide HCl)—particularly the MAO inhibitors and phenothiazines. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests may be advisable in protracted treatment. **Parenteral**—Parenteral administration is indicated primarily in acute states, and patients receiving this form of therapy should be kept under observation, preferably in bed, for a period of up to three hours. Ambulatory patients should not be permitted to operate a vehicle following injection. The usual precautions of reduced dosage should be observed when treating patients with impaired renal or hepatic function. The injectable form should not be given to patients in shock or comatose states. Reduced dosage (usually 25 to 50 mg) should be used for elderly or debilitated patients, and for children.

Anxiety and tension relieved
Alertness maintained

Librium®
(chlordiazepoxide HCl)

the successor
to the tranquilizers

ROCHE
ROCHE

197th Annual Meeting
Transactions Issue

THE Journal OF THE MEDICAL SOCIETY OF NEW JERSEY

LIBRARY
JUL 26 1963

Published Monthly Since 1904
Copyright 1963 by The Medical Society of New Jersey

Entered as second-class matter Sept. 5, 1906, at the post office, Orange, N. J., under Act of March 3, 1879
Second Class Postage Paid at Orange, N. J.

VOL. 60, NO. 7 JULY, 1963 50 Cents - $5.00 PER YEAR

CONTENTS—Pages 255 to 372

EDITORIALS— Page

Research Function and the Medical School ... 255
Traffic Accidents: 1962 ... 256

TRANSACTIONS OF THE HOUSE OF DELEGATES—

Index ... 257
Annual Reports ... 258
Resolutions ... 315
Medical Service Administration ... 325
Medical-Surgical Plan ... 328
Reference Committee Reports ... 335
Nominations and Election ... 350

ANNUAL MEETING— Page

Open Discussion on Medical-Surgical Plan ... 352
Dinner-Dance ... 365

STATE ACTIVITIES—

Personal Property Tax ... 274
198th Annual Meeting ... 364
Academy of Medicine Library Acquisitions ... 4A

Roster of Officers and Scientific Sections, Advertising Page 3A

The Medical Society of New Jersey Endorsed Plans of

ACCIDENT AND HEALTH INSURANCE
MAJOR MEDICAL EXPENSE INSURANCE
TERM LIFE INSURANCE

****SIX POINT, HIGH LIMIT ACCIDENT INSURANCE**
(Accidental Death, Dismemberment and other Accident Benefits)

Income Protection (Accident and Sickness Insurance)

$1,200 a month new maximum Basic total disability benefit

ACCIDENT: from 1st day, up to 5 years (Partial Accident Disability, half benefit up to six months)
SICKNESS: from 8th day, up to 2 years

$600 a month new maximum Extended total disability benefit, continuing benefits beyond basic coverage.

ACCIDENT: extended to LIFE
SICKNESS: extended through SEVENTH year

Major Medical

$10,000 maximum for Covered Expenses for each accident or sickness, covering member, spouse, and eligible children. $500 deductible, 20% co-insurance.

Life

$10,000 to **$50,000** of Convertible Term Life Insurance.
(Guaranteed exchangeable at any time into Permanent Cash Value life insurance)

Applications for initial $10,000 policy and additional $10,000 policies up to $50,000 total under this plan considered during the month of November each year*.

** **SIX POINT, HIGH LIMIT ACCIDENT INSURANCE**

Up to $200,000 Six Point, High Limit Accident Insurance, covering accidental death, dismemberment, loss of sight, total and permanent disability, exposure and disappearance for member.

Up to $100,000 for spouse (without disability benefit).

Applications are subject to age limits and other company rules and regulations for acceptance of risks. New members have special privileges during the first few months of membership; ask for specific details if you were recently elected and have not received notification from us.

Information and claim service are as close as your telephone.

E. & W. BLANKSTEEN

E. & W. Blanksteen Agency, Inc.

75 MONTGOMERY STREET **JERSEY CITY 2, NEW JERSEY**

DElaware 3-4340

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATON, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.
EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154
(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

OFFICERS

President, Jerome G. Kaufman, M.D. ..... Maplewood
President-Elect, Charles H. Calvin, M.D. ..... Perth Amboy
First Vice-President, John J. Bedrick, M.D. .....Bayonne
Second Vice-President, Joseph R. Jehl, M.D. ..... Clifton
Secretary, Marcus H. Greifinger, M.D. .....Newark
Treasurer, Daniel F. Featherston, M.D. ..... Asbury Park

Richard I. Nevin, *Executive Director* ..... Trenton
Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton

TRUSTEES

Samuel J. Lloyd, M.D., *Chairman* (1966) ..... Trenton
Nicholas A. Bertha, M.D., *Secretary* (1965) ..... Wharton
Jerome G. Kaufman, M.D. ..... Maplewood
Charles H. Calvin, M.D. ..... Perth Amboy
John J. Bedrick, M.D. ..... Bayonne
Joseph R. Jehl, M.D. ..... Clifton
Marcus H. Greifinger, M.D. ..... Newark
Daniel F. Featherston, M.D. ..... Asbury Park
Louis S. Wegryn, M.D. ..... Elizabeth
Louis F. Albright, M.D. (1964) ..... Spring Lake
Louis K. Collins, M.D. (1964) ..... Glassboro
Thomas C. DeCecio, M.D. (1965) ..... Cliffside Park
Joseph P. Donnelly, M.D. (1966) ..... Jersey City
Lloyd A. Hamilton, M.D. (1965) ..... Lambertville
Frank J. Hughes, M.D. (1966) ..... Gloucester
John F. Kustrup, M.D. (1966) ..... Trenton
Emanuel M. Satulsky, M.D. (1964) ..... Elizabeth
Carl N. Ware, M.D. (1965) ..... Ocean City

COUNCILORS

First District (Essex, Morris, Union, and Warren Counties) ..... Thomas S. P. Fitch, M.D., Plainfield (1966)
Second District (Bergen, Hudson, Passaic, and Sussex Counties) ..... John L. Olpp, M.D., Englewood (1965)
Third District (Hunterdon, Mercer, Middlesex, and Somerset Counties) ..... Albert F. Moriconi, M.D., Trenton (1964)
Fourth District (Burlington, Camden, Monmouth, and Ocean Counties) ..... E. Vernon Davis, M.D., Moorestown (1966)
Fifth District (Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties) .... Isaac N. Patterson, M.D., Westville (1965)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell, M.D. (1964) ..... Asbury Park
William F. Costello, M.D. (1963) ..... Dover
Joseph P. Donnelly, M.D. (1964) ..... Jersey City
Marcus H. Greifinger, M.D. (1964) ..... Newark
Luke A. Mulligan, M.D. (1964) ..... Leonia
Isaac N. Patterson, M.D. (1963) ..... Westville

Alternates

F. Clyde Bowers, M.D. (1964) ..... Mendham
Frank J. Hughes, M.D. (1964) ..... Gloucester
Joseph R. Jehl, M.D. (1964) ..... Clifton
John F. Kustrup, M.D. (1964) ..... Trenton
Elton W. Lance, M.D. (1963) ..... Rahway
John L. Olpp, M.D. (1963) ..... Englewood

DELEGATES TO OTHER STATES

New York—William F. Costello, M.D. (1963) ..... Dover
Connecticut—Lloyd A. Hamilton, M.D. (1963) .. Lambertville
New York—G. Ruffin Stamps, M.D. (1963) .... Atlantic City
Connecticut—S. Eugene Dalton, M.D. (1963) ..... Ventnor

OFFICERS OF SCIENTIFIC SECTIONS

Allergy

Arthur A. Goldfarb, M.D., *Chairman* ..... Teaneck
William I. Weiss, M.D. *Secretary* ..... Newark

Anesthesiology

Robert A. Murphy, M.D., *Chairman* ..... Mount Holly
Bernard C. Kaye, M.D., *Secretary* ..... Long Branch

Cardiovascular Diseases

Norman Reitman, M.D., *Chairman* ..... New Brunswick
Angelo J. Miglieri, M.D., *Secretary* ..... Trenton

Chest Diseases

Sanford M. Lewis, M.D., *Chairman* ..... Newark
Meyer T. Weissman, M.D., *Secretary* ..... Elizabeth

Clinical Pathology

Paul Steinlauf, M.D., *Chairman* ..... Paterson
Raymond E. Conover, M.D., *Secretary* ..... Belmar

Dermatology

Seymour L. Hanfling, M.D., *Chairman* ..... East Orange
Hugh McCulloch, Jr., M.D., *Secretary* ..... Plainfield

Gastroenterology and Proctology

Ferdinand G. Weisbrod, M.D., *Chairman*.....East Orange
James Edson, M.D., *Secretary* ..... Paterson

General Practice

Nicholas E. Marchiome M.D., *Chairman* ..... Vineland
Edward A. Schauer, M.D., *Secretary* ..... Farmingdale

Medicine

Peter H. Marvel, M.D., *Chairman* ..... Northfield
Elmer J. Elias, M.D., *Secretary* ..... Morristown

Metabolism

Werner J. Hollendonner, M.D., *Chairman* ..... Trenton
John F. Marshall, M.D., *Secretary* ..... Trenton

Obstetrics and Gynecology

Daniel B. Roth, M.D., *Chairman* ..... Teaneck
Eugene J. Slowinski, *Secretary* ..... Newark

Ophthalmology

William Rubin, M.D., *Chairman* ..... New Brunswick
Paul H. Pettit, M.D., *Secretary* ..... Ocean City

Orthopedic Surgery

Daniel J. O'Regan, M.D., *Chairman* ..... Jersey City
Daniel M. Winters, M.D., *Secretary* ..... Red Bank

Otolaryngology

James H. Spillane, M.D., *Chairman* ..... Phillipsburg
Julio T. Noguera, M.D., *Secretary* ..... Neptune

Pediatrics

Avrum L. Katcher, M.D., *Chairman* ..... Flemington
Seymour F. Kuvin, M.D., *Secretary* ..... Morristown

Psychiatry and Neurology

David J. Flicker, M.D., *Chairman* .....Newark
Eugene Revitch, M.D., *Secretary* ..... Plainfield

Radiology

W. Laurence Bonnet, M.D., *Chairman* .....Trenton
Philip D. Gilbert, M.D., *Secretary* ..... Camden

Rheumatism

Edwin L. Woolbert, M.D., *Chairman* ..... Pleasantville
Lawrence J. Denson, M.D., *Secretary* ..... Hackensack

Surgery

James B. Cummins, M.D., *Chairman* ..... Morristown
C. Buckman Katzenbach, M.D., *Secretary* .....Flemington

Urology

Bernard M. Kramer, M.D., *Chairman* ..... Perth Amboy
Milton L. Lieberman, M.D., *Secretary* ..... Elizabeth

Academy of Medicine of New Jersey Library
Selected List of Recent Acquisitions

Pediatrics

Benson, C. D.: Pediatric surgery. Chicago, Year Book Medical Publishers, 1962.

Hughes, J. G.: Synopsis of pediatrics. St. Louis, Mosby, 1963.

Pharmacology

Ciba Foundation Study Group No. 12: Curare and curare-like agents, ed. by A. V. S. De Reuck. Boston, Little, Brown, 1962.

Ciba Foundation Study Group No. 13: Resistance of bacteria to the penicillins, ed. by A. V. S. De Reuck and M. P. Cameron, Boston, Little, Brown, 1962.

Drugs of choice, 1962-1963: St. Louis, Mosby, 1963.

Psychiatry

Association for Research in Nervous and Mental Disease: Mental Retardation; proceedings of the Association, Dec. 11 and 12, 1959, New York, N. Y. Baltimore, Williams and Wilkins, 1962.

Directory of out-patient psychiatric services in New Jersey, 1962.

Carpenter, J. A.: Effects of alcohol on some psychological processes. A critical review with special reference to automobile driving skill. New Brunswick, N. J., Rutgers Univ. Center of Alcohol Studies, 1962. (Reprinted from Q. J. Studies on Alcohol, v. 23, No. 2, pp. 274-314).

Engel, G. L.: Psychological development in health and disease. Philadelphia, Saunders, 1962.

Geller, M. R.: The treatment of psychiatric disorders with insulin, 1936-1960, a selected annotated bibliography. Comp. for Psychopharmacology Service Center, National Institute of Mental Health, National Institutes of Health, Wash., D. C., U. S. Public Health Service, 1962.

Good, P. E. and Brantner, J. P.: The physician's guide to the MMPI. Minneapolis, University of Minnesota Press, 1961.

Grigor'eva, T. A.: The innervation of blood vessels. Transl. from Russian. New York, Pergamon, 1962.

Noyes, A. P. and Kolb, L. C.: Modern clinical psychiatry. Philadelphia, Saunders, 1963.

Pinel, P.: A treatise on insanity. New York, Publ. under auspices of New York Academy of Medicine, Hafner, 1962. (History of medicine series, no. 14).

Rush, B.: Medical inquiries and observations upon the diseases of the mind. New York, Publ. under auspices of the New York Academy of Medicine, Hafner, 1962. (History of medicine series, no. 15).

Schur, E. M.: Narcotic addiction in Britain and America; the impact of public policy. Bloomington, Indiana University Press, 1962.

Reference Works

Air Pollution Control Association. Directory: officers, by-laws, organization chart, committees, members. Pittsburgh, 1963.

Air Pollution Control Association. Governmental air pollution agencies: directory. Pittsburgh, Publ. in cooperation with U. S. Department of Health, Education and Welfare, 1963.

American Medical Association. Roster; A.M.A. officials and staff, executives of constituent and component medical societies, editors of society journals and bulletins. Chicago, 1962.

American Medical Association. Committee on Voluntary Health Agencies. Handbook for medical societies and individual physicians on national voluntary health agencies. Chicago, 1962.

American Public Health Association. Membership directory. Raleigh, N. C., Health Publications Institute, 1962.

Directory of social and health agencies of New York City. New York, 1963.

New Jersey Blood Bank Commission. Directory of New Jersey blood banking facilities. Trenton, 1962.

Special Libraries Association. New York Chapter, Advertising Group. Guide to special issues and indexes of periodicals; New York, Special Libraries Assoc., 1962.

Webster's new twentieth century dictionary of the English language, unabridged. 2d ed. Cleveland, World Publ. Co., 1962.

Surgery

Loré, J. M.: An atlas of head and neck surgery. Philadelphia, Saunders, 1962.

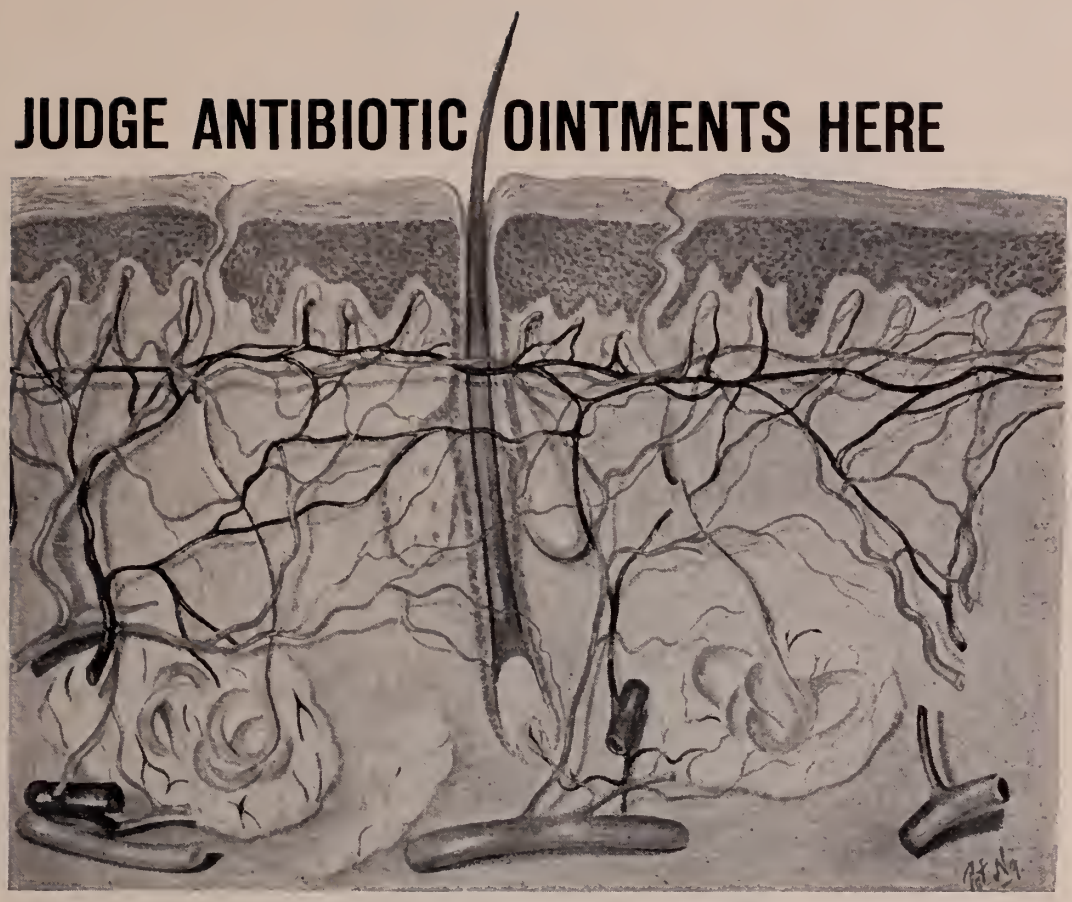
Symposium on shock, Stockholm, 1961. Shock; pathogenesis and therapy; an international symposium, sponsored by Ciba. Berlin, Springer-Verlag, 1962.

Urology

Dodson, A. I. and Hill, J. E.: Synopsis of genitourinary disease. 7th ed. St. Louis, Mosby, 1962.

Hamm, F. C. and Weinberg, S. R.: Urology in medical practice. Philadelphia, Lippincott, 1962.

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Antibiotic Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and rarely sensitizes.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN ANTIBIOTIC OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

HOW TO WIN FRIENDS...

little



New
Orange Flavored
Bayer Aspirin for Children
is sweet
all the way through,
so children
take it readily.
The GRIP-TIGHT CAP
on the bottle
helps keep them
from taking it
on their own.

Bottles of 50 tablets
(1¼ grains each)

NOW!
NEW ORANGE FLAVOR!

We will be pleased to send
professional samples on request.

THE BAYER COMPANY
Division of Sterling Drug Inc.
1450 Broadway, New York 18, N.Y.



Deltasmyl®

Theophylline (120 mg.)
Ephedrine HCl (15 mg.)
Phenobarbital (8 mg.)
(Barbituric acid derivative)
Prednisone (1.5 mg.)

for safer steroid protection from asthma

DELTASMYL® opens the airways and suppresses inflammation by combining the anti-allergic, anti-inflammatory action of prednisone with the bronchodilating, decongestant and quieting effects of theophylline, ephedrine and phenobarbital.

DELTASMYL provides prompt, prolonged relief of asthma with prednisone protection against allergens and stress, and a wider margin of safety through reduction of the effective corticoid dose.

The aim of therapy in asthma should be relief of bronchospasm by means of decongestant and bronchodilating agents—plus prednisone, not just prednisone alone.[1] Uhde[2]—using theophylline-ephedrine-phenobarbital with prednisone—reports an increase of about 25% in the action of prednisone with quicker arrest of inflammation, hypersecretion, and alveolar stasis; a marked sedative action on heart and circulation; improved ventilation. Bopp[3] also has obtained satisfactory results with the same combination, probably through synergistic enhancement of prednisone potency.

Dosage: One DELTASMYL tablet provides symptomatic relief for 4 hours or longer. Not more than 6 tablets should be taken in 24 hours. Withdraw gradually.

Precautions: DELTASMYL contains ephedrine and should not be given with epinephrine since both drugs may cause tachycardia. Carefully observe patients hypersensitive to sympathomimetic amines. Phenobarbital is a barbituric acid derivative which may be habit forming. Despite the low prednisone dose, all precautions and contraindications of corticosteroids must be heeded, since warning signs such as fluid retention or moon face may not be present. When corticosteroids are given to patients with acute or chronic bacterial infections, appropriate protection should be provided.

Contraindications: Hyperthyroidism, cardiovascular diseases, peptic ulcer, diabetes mellitus, psychotic tendencies, ocular herpes simplex, glaucoma, prostatic hypertrophy, Cushing's syndrome, arrested tuberculosis.

Supplied: Bottles of 50 tablets, on prescription only.

References: 1. Barach, A. L. and Bickerman, H. A.: Pulmonary Emphysema, Baltimore, Williams & Wilkins, 1956, p. 523. 2. Uhde, H.: Med. Monatsschr. No. 8, 505, 1959. 3. Bopp, K. Ph.: Medizinische Klinik 53:186, 1958 and Algerie Medicale 62:1081, 1958.

ROUSSEL

Roussel Corporation

155 East 44th Street, New York 17, N.Y.

in



STAPH CONTROL

procedures...
Mennen products
have proven
their quality
in hospital use.

■ **Anti-Bacterial Genteel Baby Bath** with 1% Hexachlorophene. Genteel provides excellent asepsis for infant baths, hand scrubs and continued anti-bacterial skin care at home.

■ **Anti-Bacterial Baby Magic Skin Care** with Methylbenzethonium Chloride. Famous Baby Magic offers additional skin care and protection, yet does not destroy the hexachlorophene asepsis achieved with routine baths and hand scrubs. Soothes, helps control dry skin, diaper rash, miliaria.

Also available: Medicated Mennen Baby Powder—the comfort powder used in hospitals for infant skin care.

All Mennen Baby Products available in special hospital sizes; for prices, see your Mennen Representative, or write **The Mennen Company** Morristown, N. J. Ⓜ



For comprehensive control of the whole pain complex... helps the whole patient

Like a triad, the action of Trancogesic is direct and simple as 1,2,3. Its tranquilaxant component — chlormezanone — 1. reduces emotional reaction to pain . . . 2. decreases skeletal muscle spasm . . . and 3. its aspirin component dims the patient's perception of pain. Thus, Trancogesic controls the *whole* pain complex, helps the *whole* patient — *with unsurpassed tolerance.*

Each tablet of Trancogesic contains 100 mg. of chlormezanone and 300 mg. (5 grains) of aspirin. The usual adult dosage is 2 tablets of Trancogesic three or four times daily; the dosage suggested for children from 5 to 12 years is 1 tablet three or four times daily. Reactions to Trancogesic have been minor — gastric distress, and an occasional weakness, sedation or dizziness. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. Trancogesic is contraindicated in persons known or suspected to have an idiosyncrasy to acetylsalicylic acid. WINTHROP LABORATORIES, NEW YORK 18, N. Y.

TRANCOGESIC* Winthrop

CHLORMEZANONE with ASPIRIN

*TRADEMARK 100 MG. 300 MG.

C-1778M

Our Friends...

. . . identify themselves in our times of adversity, it is said.

No better proof could be found than the patience, understanding and cooperation exhibited by the members of the medical profession during Medical-Surgical Plan's recent work stoppage.

Without exception, the physicians—and their office assistants—with whom the Plan had occasion to deal during those trying days were sympathetic and accepting of the inconveniences to which they were put.

This cooperation and support contributed in no little degree to the tremendous effort put forth by a relative handful of management employees in maintaining service. And the Plan is proud that it was able to maintain service to the high degree that it did.

Some short-cuts were necessary . . . and this means that some payments will have to be adjusted after an audit is completed. In such instances, we know that we can count on the same understanding and patience that was so manifest during the strike.

Again . . . thank you.

BLUE SHIELD ®
MEDICAL-SURGICAL PLAN
OF NEW JERSEY
500 Broad Street, Newark





"I feel like my old self again!" Balanced 'Deprol' therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

Brightens mood...relaxes tension

Energizers may stimulate the depressed patient, but they often aggravate anxiety and insomnia. Tranquilizers may help the anxious patient, but they often deepen depression. 'Deprol' avoids these "seesaw" effects; it relieves both anxiety and depression. Moreover, it does not cause liver damage, psychotic reactions or changes in sexual function.

Slight drowsiness and, rarely, allergic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

Usual Dosage: 1 tablet q.i.d. May be increased gradually, as needed, to 3 tablets q.i.d.; with establishment of relief, may be reduced gradually to maintenance levels.

▲Deprol▲®
meprobamate 400 mg.
+ benactyzine 1 mg.

WALLACE LABORATORIES / *Cranbury, N.J.*







all things considered...the decision is fo

in otitis media, having weighed the clas
cal considerations basic to management, physicia
often choose DECLOMYCIN demethylchlortetr
cycline for broad-spectrum antibiotic therap
DECLOMYCIN demethylchlortetracycline produc
activity levels higher than do other tetracyclines.
at lower dosage...and maintains them witho
significant fluctuation.

Activity is prolonged 24 to 48 hours after the la









DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE *syrup*

dose, thus helps protect against relapse—an "extra dimension" in broad-spectrum control.

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. *Side Effects* typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction.

Contraindications: none.

Syrup, 75 mg. demethylchlortetracycline/5 cc. and *Pediatric Drops,* 60 mg./cc.

Average Daily Dosage—Infants and Children: 3 to 6 mg. per lb. body weight, in 2 or 4 doses.

FEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

"Doctor... I'm so tired all the time"



Lethargic patients respond to Ritalin
(methylphenidate hydrochloride)

When lethargy is a medical problem—in convalescence, chronic fatigue, mild depression, menopause, oversedation, and senility, for example—the gentle stimulant action of Ritalin (methylphenidate hydrochloride) restores normal physical and mental activity.

In his report, Siegler[1] states: "In mild depression or in clinical exhaustion syndromes, a marginal sympathomimetic drug like methylphenidate seems to be the drug of choice for initiating therapy. It does not have the toxic effects found with the amphetamines or with the hydrazines or other antidepressants."

Other significant comments on the clinical safety of Ritalin (methylphenidate hydrochloride): "At no time was there evidence of serious toxic reactions [in a study of 185 patients]. The drug did not produce alteration in blood forming factors, kidney and liver function."[2]

"No significant toxic effects have resulted after the continuous administration of methylphenidate for more than 3 years."[3]

INDICATIONS: Chronic fatigue.

CONTRAINDICATIONS: Marked anxiety, tension, and agitation.

CAUTION: Should not be used to increase mental or physical capacities beyond normal limits. Use cautiously with epinephrine or levarterenol.

SIDE EFFECTS: Nervousness, insomnia, anorexia, nausea, dizziness, palpitations, headache, drowsiness.

DOSAGE: 10 to 20 mg. b.i.d. or t.i.d.

SUPPLIED: *Tablets*, 5 mg. (pale yellow), 10 mg. (pale blue) and 20 mg. (pale orange).

REFERENCES: 1. Siegler, P. E., in Nodine, J. H., and Moyer, J. H. (Editors): *Psychosomatic Medicine*, The First Hahnemann Symposium, Lea & Febiger, Philadelphia, 1962, p. 582. 2. Lapolla, A.: Western Med. *2*:383 (Sept.) 1961. 3. Yoss, R. E., and Daly, D. D.: Pediatrics *25*:1025 (June) 1960.

2/3098M8

C I B A SUMMIT, N.J.

Ritalin® hydrochloride (methylphenidate hydrochloride CIBA)



STARTING TOMORROW MORNING 

this capsule can help one of your overweight patients do without her favorite (fattening) foods at meals—and during all the hours in between.

Dexamyl® Spansule®

Trademark — brand of sustained release capsules

Each No. 2 capsule contains 15 mg. of Dexedrine® (brand of dextro amphetamine sulfate) and 1½ gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each No. 1 capsule contains 10 mg. of Dexedrine (brand of dextro amphetamine sulfate) and 1 gr. of amobarbital [Warning, may be habit forming].

The active ingredients of the 'Spansule' capsule are so prepared that a therapeutic dose is released promptly and the remaining medication, released gradually and without interruption, sustains the effect for 10 to 12 hours.

INDICATIONS: (1) For control of appetite in overweight; (2) for mood elevation in depressive states.

USUAL DOSAGE: One 'Dexamyl' *Spansule* capsule taken in the morning.

SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

CAUTIONS: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these rare instances withdrawal of medication is recommended. It is generally recognized that in pregnant patients all medications should be used cautiously, especially in the first trimester.

SUPPLIED: Bottles of 50 capsules.

Smith Kline & French Laboratories SK&F *Prescribing information Jan. 1963*

neither **tension,** nor **spasm,**
nor **stasis**
stays this patient
from his
appointed rounds



DECHOLIN-BB®

. . . . . especially when
UPPER G.I. COMPLAINTS
have biliary implications

Each Tablet Contains:

for nervous **tension** → BUTABARBITAL SODIUM 15 mg (¼ gr.).
WARNING: May be habit forming

for smooth-muscle **spasm** → BELLADONNA EXTRACT 10 mg (⅙ gr.).

for biliary/intestinal **stasis** → DEHYDROCHOLIC ACID 250 mg. (3¾ gr.).

Average adult dose: 1 or, if necessary, 2 tablets three times daily. **Precautions:** Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction; caution drivers against possible drowsiness. **Side effects:** Dehydrocholic acid may cause transitory diarrhea; belladonna may cause blurred vision and dry mouth. **Contraindications:** Biliary tract obstruction, acute hepatitis, glaucoma, prostatic hypertrophy. **Available:** DECHOLIN-BB, bottles of 100 tablets. **Also:** DECHOLIN® with Belladonna (dehydrocholic acid, 250 mg.; belladonna extract, 10 mg.) and DECHOLIN® (dehydrocholic acid, 250 mg.), bottles of 100 and 500 tablets.

AMES COMPANY, INC.

54MR243



Relieves Anxiety and Anxious Depression

The outstanding effectiveness and record of safety with which 'Miltown' (meprobamate) relieves anxiety and anxious depression has been clinically authenticated time and again during the past eight years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more than any other tranquilizer in the world.

Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

Usual dosage: 1 or 2 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50.

the original meprobamate

Miltown®

WALLACE LABORATORIES / *Cranbury, N.J.*

CM-9240

PROFESSIONAL LIABILITY INSURANCE PROGRAM

officially endorsed by

THE MEDICAL SOCIETY OF NEW JERSEY

PROTECTION for Professional Acts and Professional Premises Liability for members of The Medical Society of New Jersey by the First American Liability Insurance Company.

LOSS CONTROL. Your County Medical Review and Advisory Committee will evaluate malpractice cases and recommend the action which would be most favorable for the Medical Profession, the Defendant Doctor, the Patient and the Public. This program permits understanding of the complex problems involved in such cases and calls for close cooperation between the Medical Profession and Insurance Company.

MEDICO-LEGAL FORMS are furnished to each insured doctor to help in reducing claims or dissatisfied patients. Failure to use forms does not affect the doctor's insurance coverage or his eligibility for insurance.

INSURANCE COUNSELING. Insurance counseling and advice, available at all times, without cost, to help you with your Professional Liability insurance problems.

CANCELLATION. No policy will be cancelled or non-renewed without prior consultation between your Society and the Company and this is a matter of complete cooperation for the best interests of all concerned.

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY

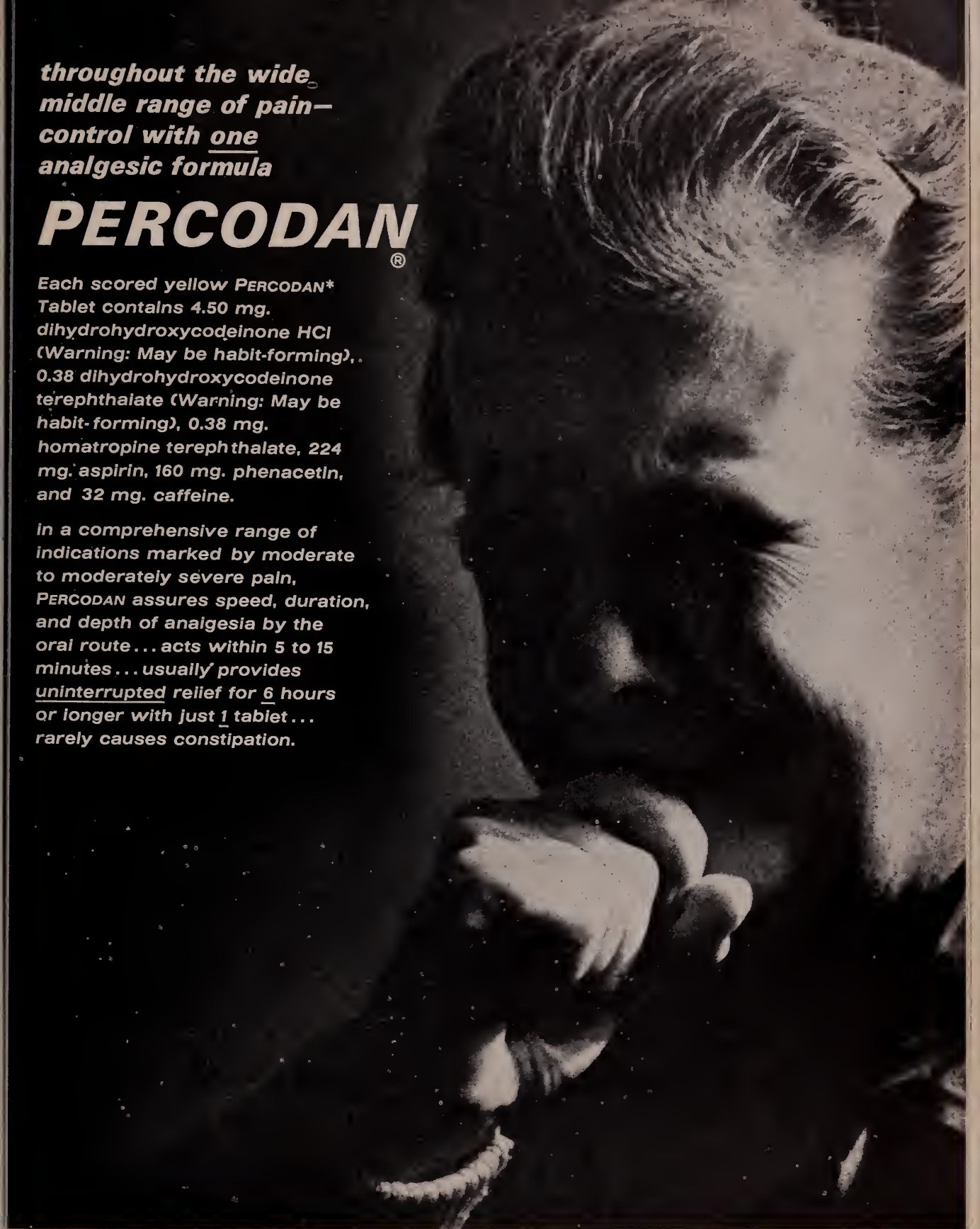
Policies Guaranteed Non-assessable

Professional Liability Department

123 CLEVELAND STREET — ORANGE, NEW JERSEY

Joseph A. Britton, Manager — ORange 3-2575

Home Office: Wakefield, Mass.



throughout the wide middle range of pain— control with one analgesic formula

PERCODAN®

Each scored yellow PERCODAN* *Tablet contains 4.50 mg. dihydrohydroxycodeinone HCl (Warning: May be habit-forming), 0.38 dihydrohydroxycodeinone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.*

in a comprehensive range of indications marked by moderate to moderately severe pain, PERCODAN *assures speed, duration, and depth of analgesia by the oral route . . . acts within 5 to 15 minutes . . . usually provides uninterrupted relief for 6 hours or longer with just 1 tablet . . . rarely causes constipation.*

Average Adult Dose—1 tablet every 6 hours. **Side Effects and Contraindications**—Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. **Also available:** PERCODAN®-DEMI, containing the complete PERCODAN formula but with only half the amount of salts of dihydrohydroxycodeinone and homatropine. Both products are on oral Rx in all states where laws permit. Narcotic order required. **Literature on request.**

ENDO LABORATORIES Richmond Hill 18, New York

Endo®

*U. S. Pats. 2,628,185 and 2,907,768



NTz Nasal Spray gives prompt, dependable decongestion of the nasal membranes for fast symptomatic relief of hay fever. The first spray shrinks the turbinates, restores nasal ventilation and stops mouth breathing. The second spray, a few minutes later, improves sinus ventilation and drainage. Excessive rhinorrhea is reduced.

NTz Nasal Spray also provides decongestive relief for head colds, perennial rhinitis and sinusitis. Supplied in leakproof, pocket-size, squeeze bottles of 20 ml. and in bottles of 30 ml. with dropper.

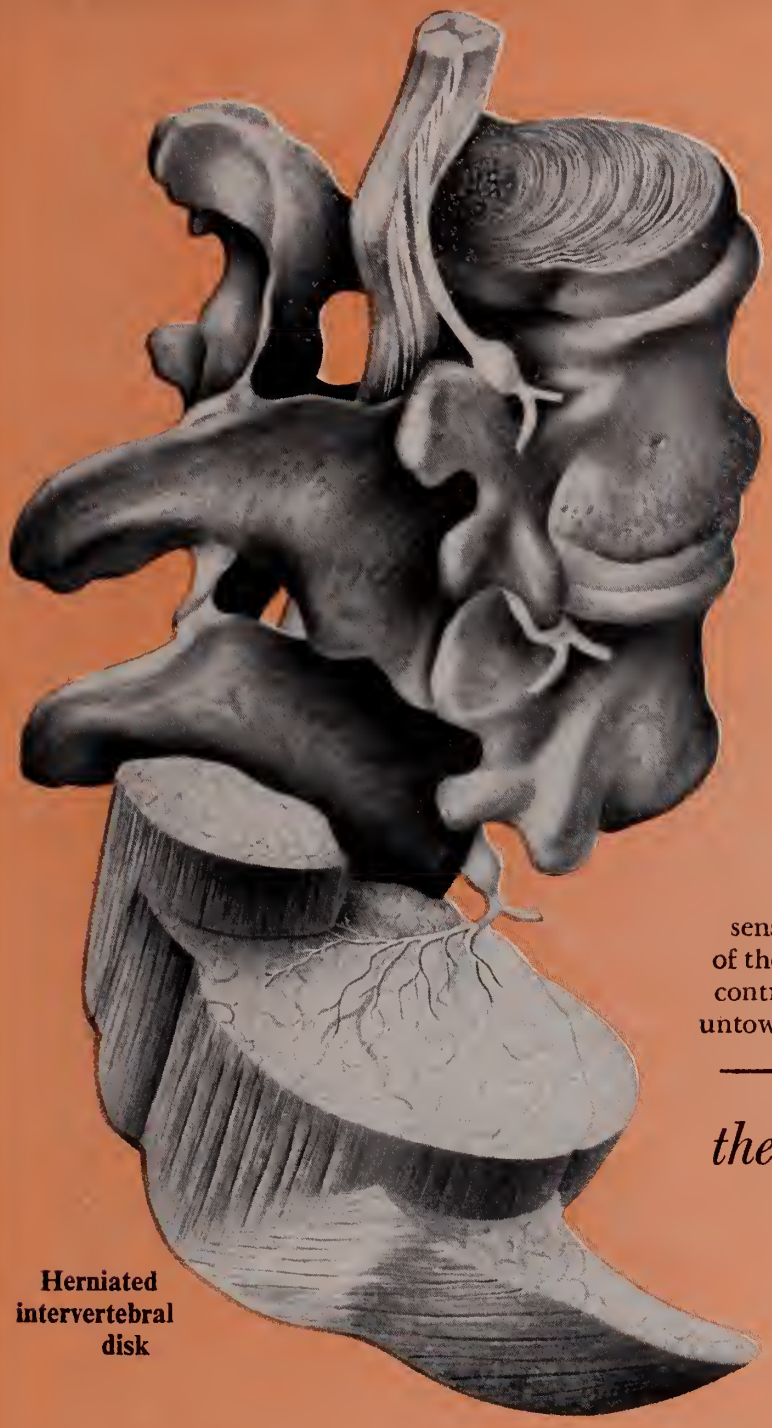
NTz® Nasal Spray

NTz is more than a simple vasoconstrictor. It contains [N]eo-Synephrine® HCl 0.5%—the efficacy of which is unexcelled—to shrink nasal membranes and provide inner space; [T]henfadil® HCl 0.1% for topical antiallergic action; and [Z]ephiran® Cl 1:5000 (antibacterial wetting agent) to promote the spread of the decongestant components to less accessible nasal areas.

NTz is well tolerated and does not harm respiratory tissues.

NTz, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium as chloride, refined), trademarks reg. U.S. Pat. Off. 1796M

Winthrop Winthrop Laboratories
New York 18, N.Y.



Herniated intervertebral disk

When pain is prominently associated with skeletal muscle spasm, ROBAXISAL effectively combats both pain and spasm. If sedation is also indicated, prescribe ROBAXISAL-PH.

Side effects, such as lightheadedness, slight drowsiness, dizziness, and nausea may occur rarely in patients with intolerance to drugs, but they usually disappear on reduction of dosage.

Contraindicated for patients hypersensitive to aspirin or other components of the formulations. There are no specific contraindications to methocarbamol, and untoward reactions are not to be expected.

*the patient had 'pain & spasm'**



*Skeletal muscle spasm is a two-headed dragon of 'PAIN & SPASM'

ROBAXISAL®

Robins

Each pink-and-white laminated ROBAXISAL tablet contains:
ROBAXIN (methocarbamol, Robins) ..... 400 mg. Aspirin (5 gr.) ..... 325 mg.
U.S. Pat. No. 2770649

ROBAXISAL®-PH

Each green-and-white laminated ROBAXISAL-PH tablet contains:
ROBAXIN (methocarbamol, Robins) ..... 400 mg. Phenacetin (1½ gr.) ..... 97 mg. Aspirin (1¼ gr.) ..... 81 mg. Hyoscyamine sulfate ..... 0.016 mg. Phenobarbital (⅛ gr.) ..... 8.1 mg.
(Warning: May be habit-forming)

A. H. ROBINS CO., INC., Richmond 20, Virginia

most effective in the obese diabetic...

Recent reports suggest... insulin and sulfonylureas may accelerate lipogenesis, fat accumulation, weight gain; thus appear to aggravate obesity in diabetics[1-5]...serum "insulin" levels are often elevated in obese diabetics[2,3,6]...DBI (phenformin HCl) reduces high blood sugars, lowers elevated "insulin" levels, tends to reduce body weight toward normal.[1,3,7-9]

DBI and DBI-TD (phenformin HCl), administered to ketoacidosis-resistant diabetics requiring hypoglycemic therapy: **A.** act to reduce high blood sugar without increasing fat synthesis or weight gain as insulin and sulfonylureas tend to do. **B.** do not increase already elevated endogenous insulin levels; may, indeed, act to restore more normal insulin levels. **C.** favor reduction of weight towards normal.

Insulin is still the essential hypoglycemic agent for the ketoacidosis-prone diabetic. However, in the ketoacidosis-resistant obese diabetic phenformin appears to be the hypoglycemic of choice to help avoid weight gain or reduce adiposity, a factor tending to make control more difficult and to increase the likelihood of complications.



Summary: Indicated in stable adult diabetes, sulfonylurea failures and unstable diabetes. Gastrointestinal side effects occurring more often at higher dosage levels abate promptly upon dosage reduction or temporary withdrawal. Occasionally an insulin dependent patient will show "stable" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" acidosis, and treated accordingly. Use with caution in severe liver disease. Not recommended without insulin in acute complications (acidosis, coma, infections, gangrene, surgery). See product brochure for full information.



Bottles of 100 and 1,000 tablets



Bottles of 100 and 1,000 capsules

Bibliography: 1. Williams, R. H.: Textbook Endocrinology, Ed. 3, Saunders, Philadelphia 1962, p. 610. 2. Gordon, E. S.: Metabolism 11:819, 1962. 3. Grodsky, G. M. et al.: Metabolism 12:278, 1963. 4. Sadow, H. S.: Metabolism 12:333, 1963. 5. West, K. M. and Tophoj, Metabolism 10:689, 1961. 6. Yalow, R. S. Berson, S. A.: Diabetes 9:254, 1960. 7. Weller et al.: Scientific Exhibit, A.M.A., June 1962 Weller, C. et al.: Metabolism 11:1134, 1962 Radding, R. S. et al.: Metabolism 11:404, 1

tablets 25 mg.

DBI®

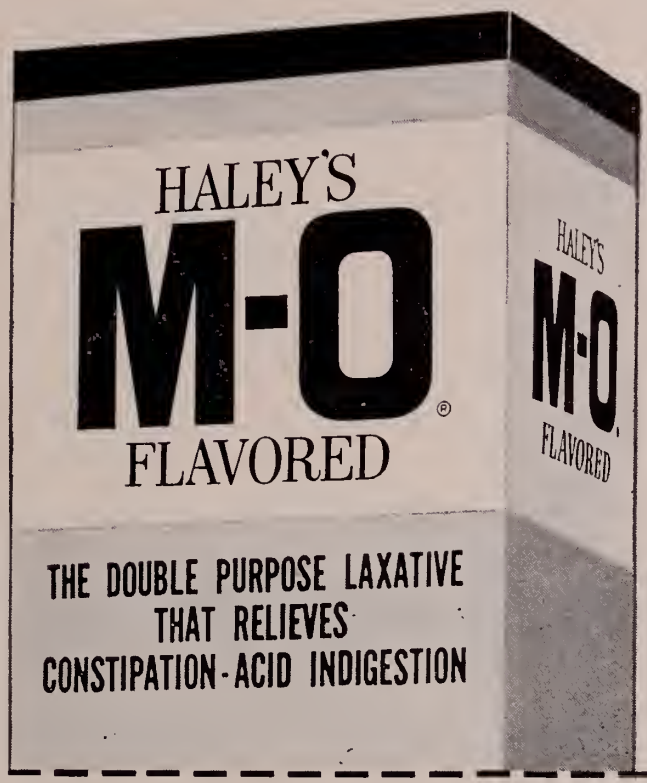
timed-disintegration capsules 50 m

DBI-TD®

BRAND OF PHENFORMIN HC

U. S. VITAMIN & PHARMACEUTICAL CORP. 800 SECOND NEW YORK 17,

NOW ALSO IN FLAVORED FORM!



BOTTLES OF
4 OZ., 8 OZ.,
1 PT., 1 QT.

Antacid–Laxative–Lubricant to help correct constipation

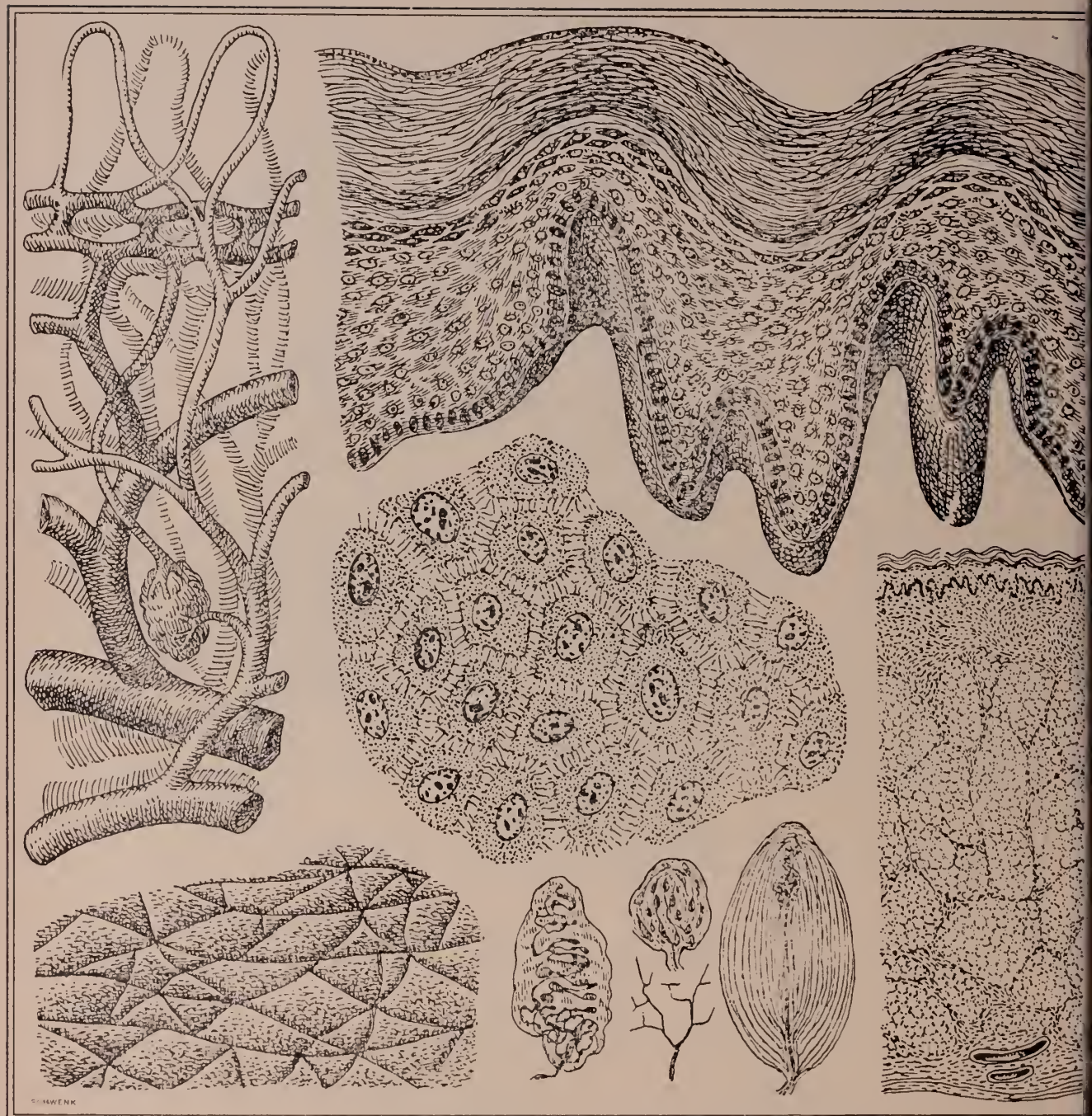
Magnesium Hydroxide plus pure mineral oil make *Haley's M-O* a smooth working antacid-laxative-lubricant that efficaciously relieves constipation and attendant gastric hyperacidity.

The oil globules in *Haley's M-O* are minutely subdivided to assure uniform distribution and thorough mixture with intestinal contents. Oil leakage is thus avoided and a comfortable evacuation is effected through the stimulation of normal intestinal rhythm and blunted defecation reflex.

May we send samples for your evaluation? Just write:

THE CHAS. H. PHILLIPS CO.

Division of Sterling Drug Inc., 1450 Broadway, New York 18, N. Y.



kin Deep

ergic and inflammatory dermatoses, luding psoriasis, have in many patients vn dramatic response to ARISTOCORT amcinolone systemic therapy. But it also vides gratifying symptomatic control h only minimal interference with r metabolic functions. In this respect, ISTOCORT Triamcinolone, when com- ed with other corticosteroids, old and new, istinguished. Typical steroid problems of ium retention and edema, undesirable horia, or voracious appetite and excessive ght gain rarely occur.

ISTOCORT Triamcinolone is indicated n anti-inflammatory, anti-allergic action lucocorticoids is desired. SIDE EFFECTS of ocorticoids generally: Cushingoid effects, sutism, leucopenia, purpura, vertigo, fatigue, increased hyperglycemia, osteoporosis, gastrointestinal hemorrhage, cataracts, growth suppression in children and increased intracranial pressure. Other glucocorticoid effects thought more likely to occur with triamcinolone: reversible weakness of muscles and flushing of face.

PRECAUTIONS: ARISTOCORT Triamcinolone should be used with extreme caution in viral infection, particularly herpes simplex and chicken pox, in tubercular or fungal infection, in active peptic ulcer, acute glomerular nephritis or myasthenia gravis.

FORMULA—Tablets (scored) containing 1 mg., 2 mg. or 4 mg. of triamcinolone. Syrup — 2 mg. of triamcinolone diacetate per 5 cc. (5 mg. of triamcinolone diacetate is equivalent to 4 mg. of triamcinolone).

Aristocort®
Triamcinolone

laximum steroid benefits with minimum steroid penalty

derle LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York
164-R-3 (DC31-S)



so sorry...



we can't pay your tolls

However...There's a full 12 month or 12,000 mile guarantee with each new DATSUN. Compared with our leading competitor, DATSUN offers more of everything—longer guarantee, more horsepower, more speed, more doors (4), more passenger and trunk room, terrific economy! • Come in and test drive the new DATSUN. See for yourself why we dare to compare this beauty from Japan with all others. • Other models to choose from: 4 DOOR STATION WAGON $1816.— ½ TON PICK UP $1545.—FWD GP PATROL $2658.



$1616 P.O.E.*
12 MONTHS OR 12,000 MILES GUARANTEE
*Plenty Of Extras

"OPERATES ON A KEY AND SMALL CHANGE...MOSTLY FOR TOLLS."

DATSUN

NISSAN MOTOR CORP. IN U.S.A. 221 FRELINGHUYSEN AVE., NEWARK, N. J.

These 20 New Jersey DATSUN Dealers are at your service:

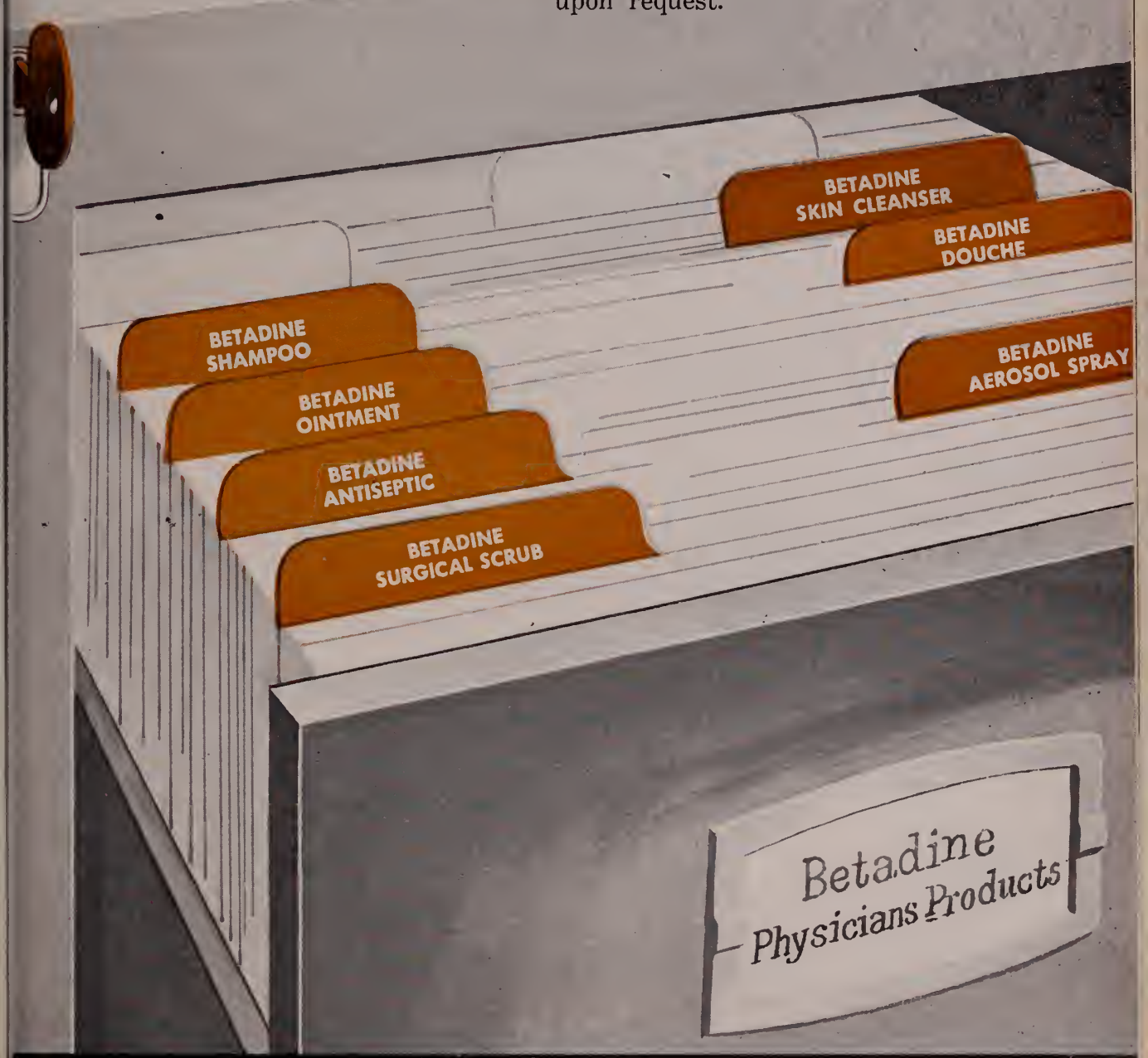
REICHLIN'S SPORT CENTER, Route No. 130 and Farnsworth Avenue, Bordentown
APGAR'S GARAGE, Route No. 206, Chester
OXFORD MOTORS, Route No. 46, East Paterson
SPREEN'S AUTO SALES, 458 Passaic Street, Hackensack
IMPERIAL IMPORT, 320 Haddon Avenue, Haddonfield
SUBURBAN POWER EQUIPMENT, 319 State Highway No. 10, Hanover
MODERN AUTO SALES, 575 Chancelor Avenue, Irvington
TOMS RIVER IMPORTED CARS, Route No. 37 and Central Avenue, Island Heights
WASHINGTON SALES, 370 Broad Street, Keyport
TOWNE AUTO SALES, 118 Fort Lee Road, Leonia
OXFORD MOTORS, 230 Route No. 17, Lodi
ZEMAN MOTORS, Route No. 17 and Ramapo Avenue, Mahwah
KINNEY MOTORS, INC., 1010 Broad Street, Newark
BIANCA MOTORS, INC., 316 Memorial Parkway, New Brunswick
FOREIGN CAR CO., Route No. 22, North Branch
WILLIAM JAY CLARK, 505 Somerset Street, North Plainfield
POMPTON AUTO SALES, Route No. 23, Pompton Plains
LAYNE MOTORS, INC., 465 Lehigh Avenue, Union
S. & S. MOTORS, Route No. 23, Wayne
HORNUNG AUTOMOTIVE SALES & SERVICE, 494 Valley Road, West Orange

etadine®
vidone-Iodine
roducts
lock a wide
nge of usefulness

Betadine Products, in all seven dosage for contain povidone-iodine, a complex of polyvi pyrrolidone and iodine, providing all the ger cidal properties of elemental iodine . . . yet Be dine (povidone-iodine) is nonirritating, nonse tizing, and nontoxic to skin or mucosa.

Betadine Products are effective in preventing a treating a variety of infections frequently countered in the practice of otolaryngology, ort pedics and orthopedic surgery, obstetrics a gynecology, oral surgery, pediatrics, surgery a dermatology.

The clinical results reported under various c ditions of use make Betadine (povidone-iodi preparations valuable adjuncts both in the h pital and in private practice. Literature availa upon request.



PHYSICIANS PRODUCTS CO., INC.
PETERSBURG, VIRGINIA

Webcor Music Man

STEREOPHONIC HIGH FIDELITY TAPE RECORDER

...the ultimate in tape recorder performance!



PRICED AT only $198.80

- 2 and 4 track stereo operation
- 3 speeds—1⅞, 3¾, and 7½ ips.
- New, simplified "push-lever" operation
- Self-contained stereo record and playback
- Digital tape counter with pushbutton reset
- Dual volume controls—one for each channel
- Dual bass and treble controls

If you're the "one in a hundred" with a highly critical ear for perfection in sound, you'll be satisfied with nothing less than the new Webcor "MUSIC MAN" stereo tape recorder. And it's ever so simple to operate! Just push the lever up to "Play"... push it down to "Stop"... move it to the left to "Rewind"... to the right for "Fast Forward." Treat yourself to a thrilling new hearing experience. Ask for a demonstration today at—

Write for catalog to Exclusive N. J. Wholesale Distributors

ALL-STATE DISTRIBUTORS

INCORPORATED

457 CHANCELLOR AVE. NEWARK, N. J.

WAverly 3-4900

Get your low-back patient back to work in days instead of weeks



You can expect rapid results from 'Soma' (carisoprodol)—because this unique drug breaks up both the spasm and pain of low-back syndrome at the same time.

Your patients will usually begin to feel better within a few hours. And as Kestler demonstrated in a controlled study of 212 consecutive patients with low-back problems: the average time for full recovery was only 11.5 days with 'Soma' (carisoprodol), 41 days without it. (J.A.M.A., April, 1960.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely.

USUAL DOSAGE: ONE 350 MG. TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

Soma®
carisoprodol

Wallace Laboratories
Cranbury, New Jersey

mudrane®

the bronchodilator
with the intermediate dose of KI

A combination of the four most widely used drugs for treatment of asthma. Each tablet contains Aminophylline 130 mg., Ephedrine HCl 16 mg., Phenobarbital 22 mg. (Warning: May be habit forming), Potassium Iodide 195 mg.—compounded for prompt absorption and balanced action, and buffered for tolerance.

Dosage in asthma, emphysema, bronchiectasis, chronic bronchitis: One tablet with a full glass of water, 3 or 4 times a day.

Precautions: The usual precautions for aminophylline-ephedrine-phenobarbital mixtures. Iodides may cause nausea, and very long use may cause goiter. Discontinue if symptoms of iodism develop.

Contraindications of Iodides: Tuberculosis, pregnancy (to protect the fetus against possible depression of thyroid activity).

mudrane® GG

The Mudrane GG formula is identical to Mudrane except that Glyceryl Guaiacolate, 100 mg. replaces the Potassium Iodide as the mucolytic-expectorant.

Glyceryl Guaiacolate has no known side effects.

Caution: Federal law prohibits dispensing these products without prescription

COMPLETE INFORMATION AND CLINICAL SAMPLES SENT UPON REQUEST

Dispensed in bottles of 100 and 1000 tablets

WM. P. POYTHRESS & COMPANY, INC., RICHMOND, VA.
Manufacturers of ethical pharmaceuticals since 1856

LONG TERM AUTO LEASING

. . . A SERVICE ESPECIALLY PLANNED FOR DOCTORS!

M.D. PLATES FREE, TOO!

AAL LONG TERM SINGLE CAR AND FLEET RENTALS

Call ORange 6-7137 or

MAIL COUPON TODAY

Lease a brand new Cadillac or other fine car from American and you'll never buy again. Save money, time and trouble. One modest monthly payment takes care of everything . . . insurance, maintenance, repairs, depreciation . . . and the payments are 100% tax deductible! Borrow a car—free of charge—in case of accident or breakdown.

INCLUDES

- Registration and plates
- Full maintenance
- Insurance

Liability $250/$500,000
Property damage $20,000
Deductible collision, fire and theft

AMERICAN AUTO LEASING COMPANY
120 Halsted St., East Orange, N. J.
Please send me the AAL Long Term Leasing Plan.
Wide Selection of '63 Models
Special requirements _____
_____
Name _____
Address _____
City _____ State _____

ALL YOU BUY IS GAS AND OIL

ASK FOR BROCHURE

AAL

AMERICAN AUTO LEASING COMPANY

120 Halsted Street, East Orange, New Jersey • ORange 6-7137

KESSLER ASSOCIATES, INC.

ORTHOTICS, Inc.

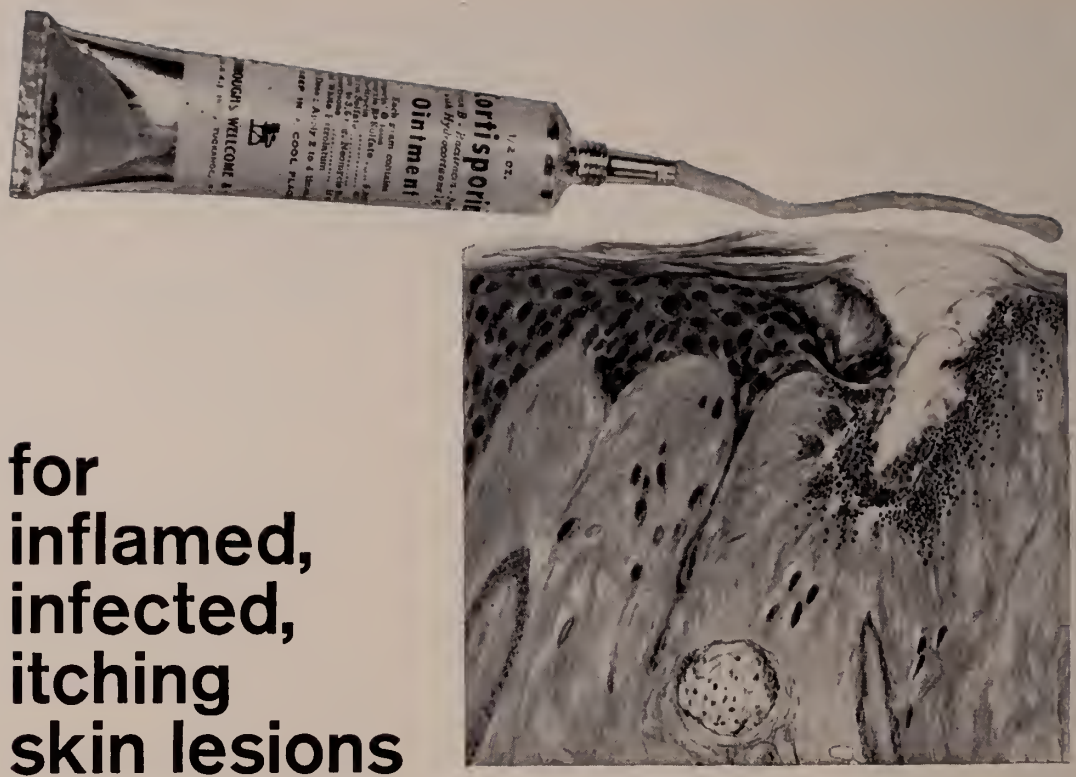
Certified Fitters and Facilities

ARTIFICIAL LIMBS BRACES

COMPLETE REHABILITATION EQUIPMENT

166 CLINTON AVENUE NEWARK, NEW JERSEY

Bigelow 2-5431



for inflamed, infected, itching skin lesions

anti-inflammatory / bactericidal / antipruritic

'CORTISPORIN'® brand OINTMENT

POLYMYXIN B-BACITRACIN-NEOMYCIN WITH HYDROCORTISONE 1%

Each gram contains:
'Aerosporin'® brand Polymyxin B* Sulfate 5,000 Units; Zinc Bacitracin 400 Units; Neomycin Sulfate 5 mg.; Hydrocortisone 10 mg. (1%).

- relieves pain and itching
- reduces inflammation and edema
- provides bactericidal action against most gram-positive and gram-negative organisms, including *Pseudomonas aeruginosa*
- rarely sensitizes

General Indications: Wherever inflammation or infection occurs and is accessible for topical therapy, as in burns, wounds, skin grafts; and plastic proctologic, gynecologic, or general surgical procedures.

Dermatologic Indications: Atopic, contact, stasis, infectious eczematoid, and lichenoid dermatitis; neurodermatitis, eczema, pyoderma; anogenital pruritus; primary dermatoses with or without secondary infection; external otitis.

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Contraindications: Local application is contraindicated in tuberculous conditions of the skin, herpes simplex, vaccinia and varicella.

Available: In tubes of ½ oz. with applicator tip and ⅛ oz. with ophthalmic tip. Although the ⅛ oz. tube is intended for ophthalmic use, it may be used topically.

Complete literature available on request from Professional Services Dept. PML.

*U.S. PAT. NOS. 2,565,057 AND 2,695,261

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain...not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

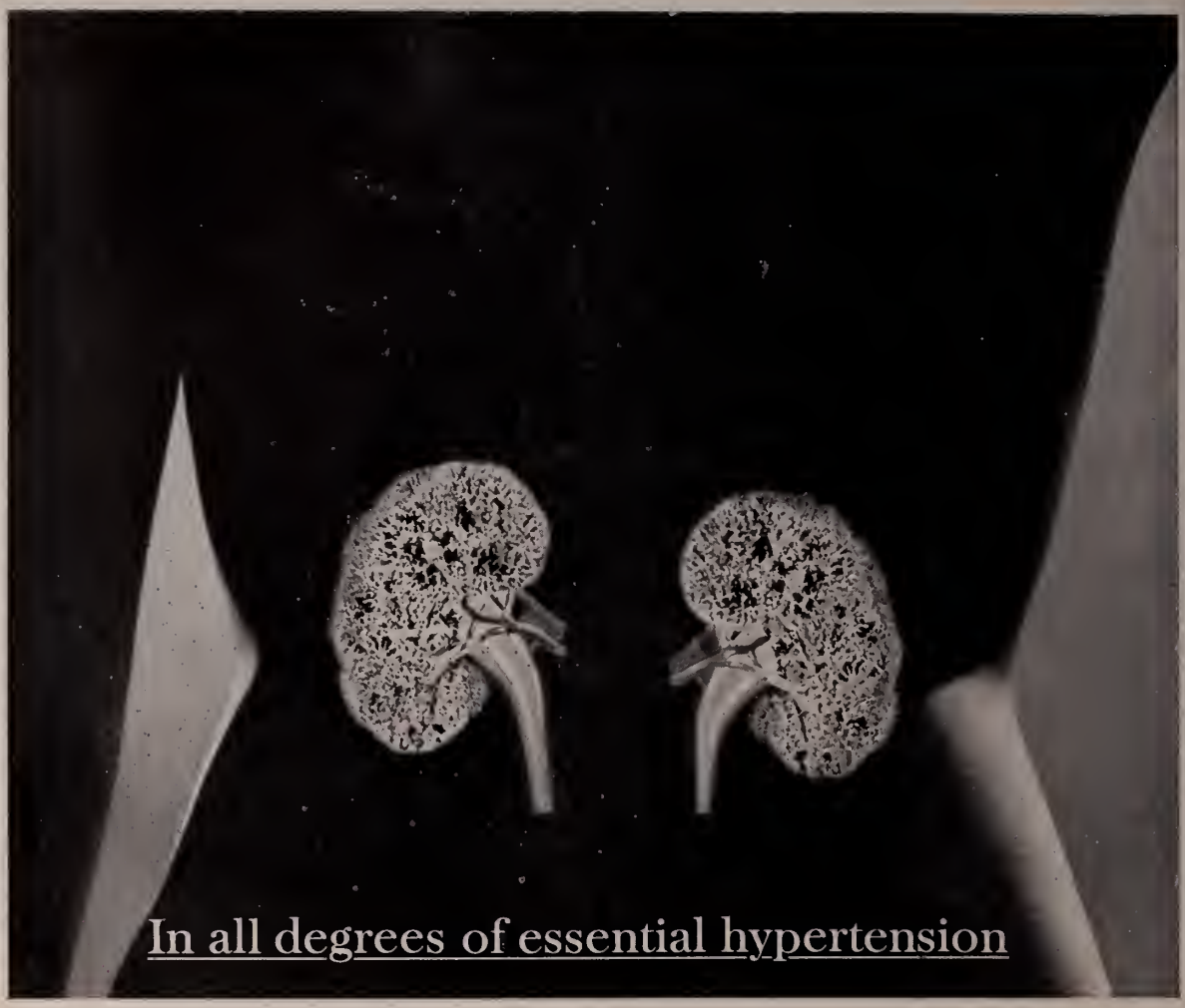
carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

®WALLACE LABORATORIES / *Cranbury, N.J.*

CSO-9193



Help protect the kidneys and other threatened organs

When treatment of hypertension is effective the danger of damage to the renal system is reduced.[1-2] "Hypertensive patients suffer from vascular deterioration roughly proportional to the severity of the hypertension... Reduction of blood pressure to normotensive levels reduces or arrests the progress of vascular damage with a resultant decrease in morbidity and mortality."[1] *Because Rautrax-N lowers blood pressure so effectively, it will help provide this important protection not only for the kidneys but also for the heart and brain of your hypertensive patients.* Rautrax-N is effective in mild,[3] moderate,[3,4] or severe hypertension.[4,5]

Dosage: Initially, 1 to 4 tablets daily preferably at mealtime. For maintenance, 1 or 2 tablets daily.

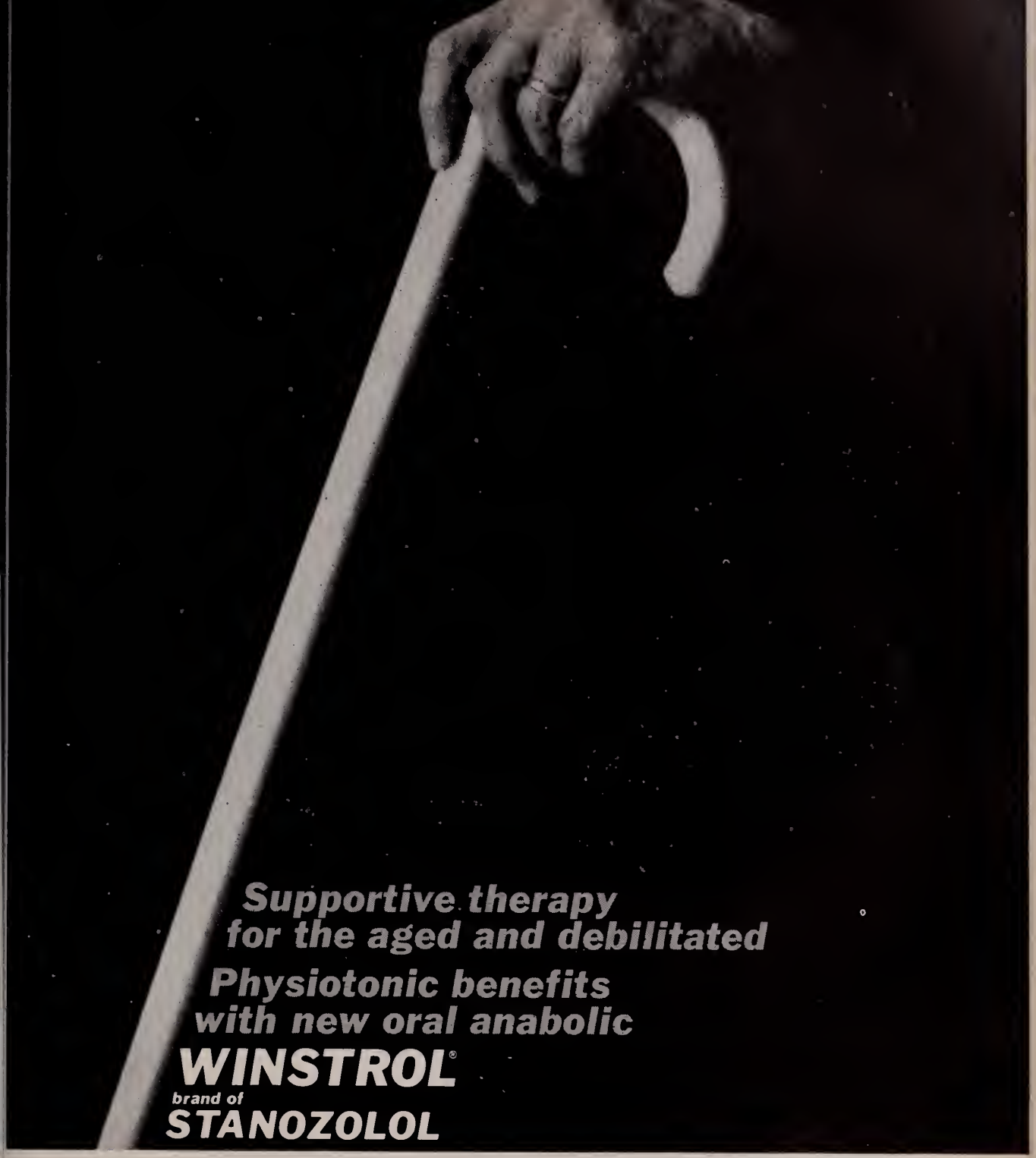
Side effects and precautions: Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression. Caution indicated in use with depression, suicidal tendencies, peptic ulcer. Minor side effects: diarrhea, weight gain, nausea, drowsiness. Bendroflumethiazide may cause reversible hyperuricemia and/or gout, unmask latent diabetes, increase glycosuria in diabetics. Caution indicated in use for patients on digitalis, with severely damaged kidneys, renal insufficiency, increasing azotemia, cirrhosis. Contraindicated in complete renal shutdown. Minor side effects: leg or abdominal cramps, pruritis, paresthesias, mild rashes.

Supply: Rautrax-N—capsule-shaped tablets providing 50 mg. Raudixin® [Rauwolfia serpentina whole root], 4 mg. Naturetin® [bendroflumethiazide], and 400 mg. potassium chloride. *Rautrax-N Modified*—50 mg. Raudixin [Rauwolfia serpentina whole root], 2 mg. Naturetin [bendroflumethiazide], and 400 mg. potassium chloride, in capsule-shaped tablets. For full information, see your Squibb Product Reference or Product Brief.

References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

SQUIBB
Squibb Quality
—the Priceless Ingredient
SQUIBB DIVISION Olin

RAUTRAX®-N RAUWOLFIA SERPENTINA WHOLE ROOT (50 MG.), BENDROFLUMETHIAZIDE (4 MG.) WITH POTASSIUM CHLORIDE (400 MG.), SQUIBB



Notable increase in vigor, strength and sense of well-being

L (stanozolol-Winthrop), a heterocyclic steroid, combines abolic effects with outstanding tolerance, stimulates appe- omotes weight gain ... restores a positive metabolic balance. acts the catabolic effects of concomitant corticosteroid or apy. WINSTROL (stanozolol-Winthrop) rebuilds body tissue uilds strength, confidence and a sense of well-being in con- sociated with excess protein breakdown, insufficient protein l inadequate nitrogen and mineral retention.

ts and Precautions: Prolonged administration can produce tism, acne or voice change. In an occasional patient, edema observed and in young women the menstrual periods have er and shorter. These side effects are reversible, and pa- eiving prolonged treatment should be examined and ques- tioned periodically so that, should side effects appear, the dosage may be reduced or administration of the drug discontinued for a time. In patients with impaired cardiac and renal function, there is the possibility of sodium and water retention. Liver function tests may reveal an increase in bromsulphalein retention, particularly in elderly patients. In such cases, therapy should be discontinued. Although it has been used in patients with cancer of the prostate, its mild androgenic activity is considered by some investigators to be a contraindication.

Dosage: Usual adult dose, 1 tablet t.i.d. before or with meals; young women, 1 tablet b.i.d.; children (school age): up to 1 tablet t.i.d.; children (pre-school age): ½ tablet b.i.d. Available as scored tablets of 2 mg. in bottles of 100. For best results, administer with a high protein diet.

WINTHROP LABORATORIES, NEW YORK 18, N. Y.

ed improvement in appetite / Measurable weight gain Winthrop

BRUNSWICK PARK NURSING HOME

NEW JERSEY'S NEWEST, MOST MODERN HOME FOR THE CONVALESCENT, CHRONICALLY ILL, AGED AND RETIRED



NO STEPS

RANCH TYPE

MOST UP-TO-DATE EQUIPMENT

Reasonable Rates

Inspection Invited

- Referring physicians have full medical privileges
- Physical and recreational therapy program
- Experienced professional staff
- Special diets
- Complete 24-hour general nursing care
- Audio-Visual Nurses' call system for every bed
- Air-conditioned lobby, lounge and dining room
- Private & semi-private rooms
- Sanitary all-stainless steel kitchen, tiled to ceiling
- Tiled Wheel-in Showers and baths
- Piped-In music
- Spacious Outdoor Patios

ON U.S. 1 AT INTERSECTION N. J. 18 (Opposite Howard Johnson's)

Tel. 828-2400 **NEW BRUNSWICK, N. J.**

Raritan Valley Farms, Inc.

QUALITY DAIRY PRODUCTS

and

OLD FASHIONED ICE CREAM

•

STOP AT THE "MINUTEMAN"

RF

SOMERVILLE

RT. 206 RA. 5-0687

PARK RIDGE

COAT, APRON, TOWEL AND LINEN SERVICE

A Complete Linen Service for . .

PROFESSIONAL OFFICES - STORES

RESTAURANTS - FACTORIES - HOTELS

•

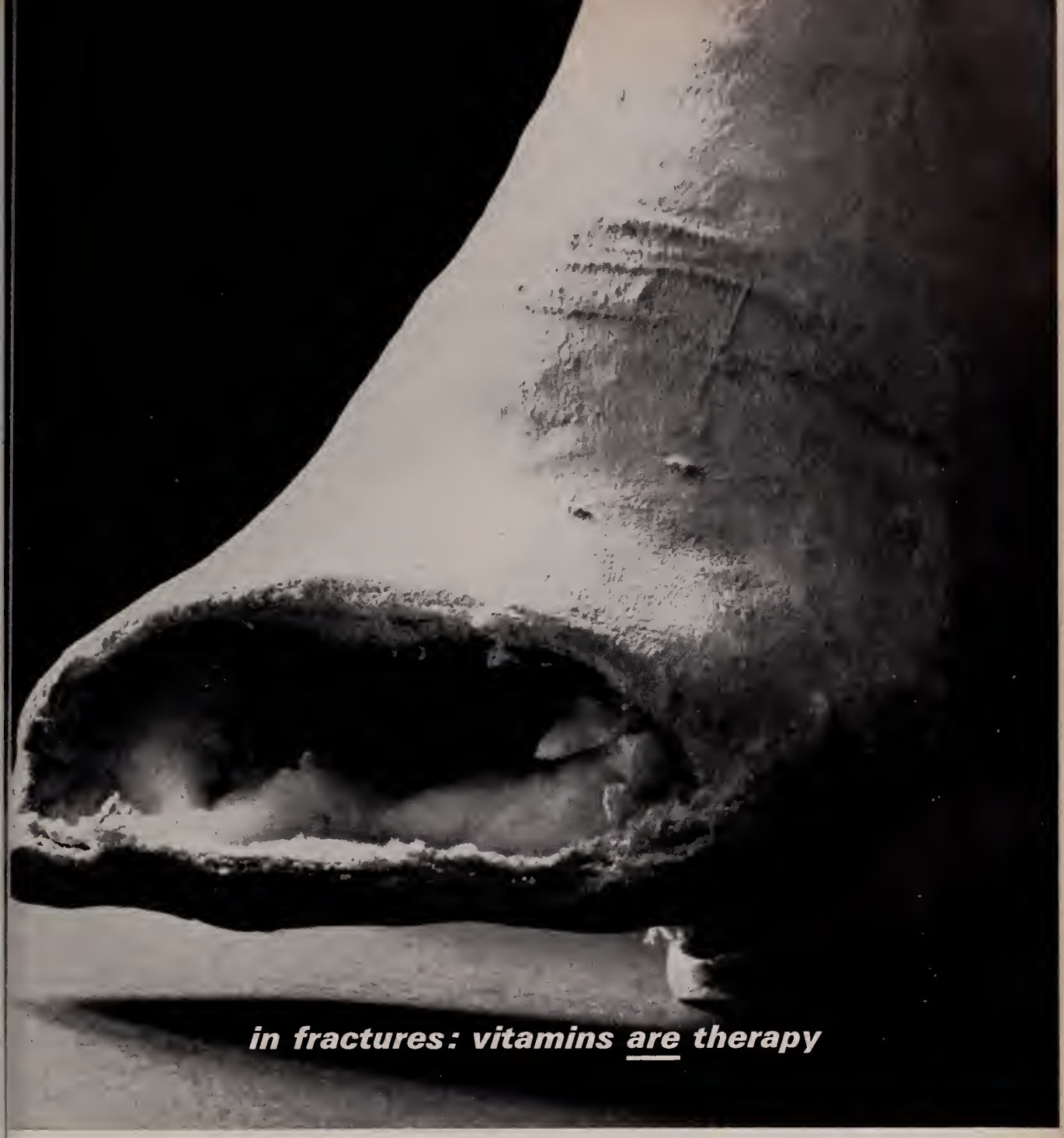
UNIFORMS TOWELS APRONS

GOWNS NAPKINS

•

95 E. 20th STREET PATERSON, N. J.

SHERWOOD 2-5543



Few factors are more fundamental to tissue and bone healing than nutrition. Therapeutic allowances of B and C vitamins are important for rapid replenishment of vitamin reserves which may be depleted by the stress of fractures. Metabolic support with STRESSCAPS is a useful adjunct to an uneventful recovery.

FOR PROFESSIONAL

RECOMMENDATION-ONLY

Each capsule contains: Vitamin B_1 (Thiamine Mononitrate)...10 mg. / Vitamin B_2 (Riboflavin)...10 mg. / Niacinamide... 100 mg. / Vitamin C (Ascorbic Acid)...300 mg. / Vitamin B_6 (Pyridoxine HCl)...2 mg. / Vitamin B_{12} Crystalline... 4 mcgm. / Calcium Pantothenate...20 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

6317-3

STRESSCAPS®

Stress Formula Vitamins Lederle



The new or early hypertensive patient



The middle-aged hypertensive woman



The geriatric hypertensive patient



The overweight hypertensive patient



When depression or peptic ulcer adds problems



Effective blood pressure regulation for the many faces of hypertension[1-5]

Important note: For best results with CAPLA (mebutamate)

To demonstrate its blood-pressure-lowering effect, 'Capla' (mebutamate) must have been taken on schedule on the day of the patient's checkup. The maximum hypotensive response occurs within 2-4 hours. Because 'Capla' (mebutamate) is promptly excreted, q.i.d. dosage should be maintained for consistent results.

Product Information: 'Capla' (mebutamate) is indicated for control of hypertension, either alone in mild cases, or in conjunction with diuretics or peripherally acting hypotensive agents in more severe cases. Its mild tranquilizing properties are often found an additional benefit to its antihypertensive action.

Drowsiness and occasional lightheadedness, usually transient, are often signs of dosage higher than necessary for therapeutic effect. There are no known contraindications to mebutamate.

Usual Dosage: One 300 mg. tablet 3 or 4 times daily, before meals and at bedtime. Dosage should be adjusted to individual requirements; for example, older patients may require lower dosage.

Composition: Each tablet contains mebutamate, 300 mg.

Supplied: Bottles of 100 white, scored tablets. Literature and samples to physicians on request.

References: 1. Corcoran, A. C., and Loyke, H. F.: J.A.M.A. *181*:1043, Sept. 22, 1962. 2. Costello, A. C.: M. Times *91*:53, Jan. 1963. 3. Holloman, J. L. S., Jr.: J. Nat. M. A. *54*:94, Jan. 1962. 4. Kheim, T., and Kountz, W. B.: New York J. Med. *62*:1596, May 15, 1962. 5. Leslie, C. H.: J. Am. Geriatrics Soc. *10*:85, Jan. 1962.

c/63 63WL30K-12

Wallace Laboratories
Cranbury, N. J.

Schering

in dermatoses amenable to topical steroid therapy

METI-DERM®

Prednisolone, 16.6 mg. in 50 Gm. container and 50 mg. in 150 Gm. container; in nonsensitizing vehicle—isopropyl myristate with inert propellants—trichloromonofluoromethane, dichlorodifluoromethane.

AEROSOL COVERS

reaches every part of the lesion, any area of involvement • instant cooling, soothing effect • controls the itch, delimits the area of erythema and edema • nonfluorinated—avoids risk of steroid absorption • easy to carry and apply away from home—no residue on the skin



Clinical Considerations: In allergic dermatoses, until the specific causative agent is identified and removed from the patient's environment, the condition may be expected to recur when therapy is terminated. If infection is present, appropriate antibacterial measures should be taken. METI-DERM (prednisolone) Aerosol should not be sprayed around the eyes. Contents of can are not flammable but are under pressure. Containers should be stored in a cool place and neither punctured nor incinerated. For complete details, consult Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey.

® prednisolone topical, Schering.

S-193R



We like visitors. We like to show them our modern equipment and latest research facilities, our exacting manufacturing techniques and unexcelled quality standards. Up to a point, that is. A white line provides the barrier that discourages further exploration. It means look but don't cross. It is a safeguard against inadvertent mishandling or misplacing of products—another precaution in an endless list of rules contributing immeasurably to the quality of the finished product.

Eli Lilly and Company · *Indianapolis 6, Indiana, U.S.A.*

Lilly

390178

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Research Functions and the Medical School

In the February 1963 *Report from Rutgers* appears a prospectus of the proposed medical school at Rutgers. The dean, DeWitt Stetten, writes that "Our school . . . will be rich in research orientation. Opportunities will be presented to secure training directly towards the Ph.D. degree in basic biological sciences." Elsewhere Dr. Stetten adds that "every student will be offered maximum opportunities for research . . . it is hoped also that a portion of the student body will find research sufficiently attractive to make this a major part of their life effort. Indeed, it is anticipated that many students will devote their remaining education to procurement of a doctorate in one of the basic medical sciences rather than the M.D."

It is as hard to be against research as to be against sin. Yet, the pressing need is for practitioners. One of the pressures behind the demand for an additional medical school in New Jersey is based on that need. New Jersey citizens in out-of-state medical schools too often make contacts there (professional or romantic) which keep them out of our state. Thus, it is suggested, we need a school right in our own state. If our second medical school is to fill the new dean's prescription though, it will not produce the crop of practitioners that New Jersey needs.

In this connection, the AMA's Council on Medical Education and Hospitals, in a recent report, deplored an overemphasis on research in medical schools. One danger, the Council suggested, would be the de-emphasis of teaching. Furthermore, research could enchant a disproportionate share of the more talented students. The undergraduate medical student, the Council feared, might become the forgotten man. And on the well-known principle of the piper's paymaster calling the tune, the Council wondered whether federal and commercial largesse might not actually sap the independence of the schools. In fact, it was possible that the fund-granting agencies (whether governmental or industrial) might actually dic-

Published Monthly Since 1904 Henry A. Davidson, M.D., Editor
Under the Direction of the Committee on Publication Theresa E. Goeke, Assistant Editor
George B. Sharbaugh, M.D., Chairman

Place of Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — EXport 4-3154
Send all communications regarding advertising to Joseph W. Cookson, 370 Morris Ave., Trenton 10, New Jersey — EXport 3-7196
Each member of the Society is entitled to receive a copy of The Journal every month

Whole Number of Issues 707

Vol. 60, No. 7 JULY, 1963 50 Cents - $5.00 per year

tate the future direction of medical schooling.

One figure cited by the Council throws this into bold relief. In 1940, medical schools spent four million dollars for research; in 1962, the research budget was 221 million dollars! (This is just the amount spent in or by medical schools—and does not include research costs outside the schools.) Believe it or not, one-half of all medical school expenses now goes into research. Thirty years ago, the figure was about 12 per cent.

That the rich get richer is an old, if cynical observation. Research money goes to schools which have had successful or well glamorized research in the past. Schools which think that their main job is to create medical practitioners suffer by comparison. They get less publicity, fewer grants, and eventually the word "practitioner" gets a new pejorative adjective: a *mere* practitioner.

This introduces another aspect—one that the Council did not mention: the snob appeal of research. To be sure, the Internal Revenue Department is more interested in the practitioner; but the intellectual community glamorizes the researcher.

For medical progress, we depend on research. But research is sterile unless there is a practitioner to deliver its product to the patient. There are many research-sponsoring vehicles: foundations, graduate programs, basic science schools, hospitals, the pharmaceutical industry. But there is only one machine for creating medical practitioners: the undergraduate medical school.

Traffic Accidents: 1962

It's a grim business. But regardless of the words of warning, the carnage on the nation's highways continues at a sickening rate. And the year 1962 stands infamously as the most tragic in the history of highway safety. According to an authoritative report by The Travelers Insurance Companies, 40,500 persons were killed last year in U.S. traffic accidents. It was an all-time high for a single year and erases the previous record of 39,969 fatalities set in 1941.

Moreover, highway accidents injured an additional 3,345,000 people in 1962. This shocking total exceeds by 10 per cent the comparable figure for 1961.

And the real tragedy lies with the public at large which finds precious little motivation for joining the battle to save lives on the highways.

Perhaps in the final analysis the communications media are armed with poor ammunition. Statistics, by and large, make poor copy even though they deal with a situation which last year directly affected 3,385,500 lives. Countless others were involved indirectly.

So the question continues to arise: how can we translate 3,385,500 casualties into a meaningful figure? Or even the 40,000 deaths.

Well, if every living soul in Montclair or Perth Amboy were destroyed by a plague—if the city were devastated—if it became a ghost town with 40,000 coffins all in a row—then you might get the picture.

Suppose that every single resident of Chicago were injured—that Chicago became one vast surgical ward. That's how many people were injured by automobiles in 1962.

It's an appalling number. Worse yet, most of these casualties were *not* caused by mechanical failure or by poor driving conditions. About 88 out of every 100 highway accidents were caused by driver error and lack of judgment. At the same time, The Travelers report also points out that more than *80 per cent of all accidents occurred in clear weather and on dry roads.* Here is mute testimony that the dramatic reduction of highway deaths and injuries can only be accomplished if we as drivers are determined to stand up and be counted in this annual battle against senseless slaughter on the nation's roadways.

Safety education is part of the doctor's job, too.

Official Transactions of the House of Delegates

197th ANNUAL MEETING OF
THE MEDICAL SOCIETY OF NEW JERSEY

HADDON HALL, ATLANTIC CITY, N. J.

MAY 11 - 15, 1963

NOTE TO READERS

The annual reports and transactions of the House of Delegates of the 197th Annual Meeting of The Medical Society of New Jersey are bound together in this issue of THE JOURNAL.

Actions taken by the House of Delegates are indicated in bold-face small type in the reports.

INDEX

* Accreditation of Hospitals for the Chronically Ill and Long-Term Patient (#8) .. 319
* AMA Delegates' Responsibility (#15) 323
* AMA Intern Program (#2, #3) 315, 316
** AMA Lists of Physicians 264
** AMA Publicity on Compensation of Interns and Residents 268
Annual Meeting 275
** Annual Meeting Publicity, 1962 269
** Assembly Resolution, New Jersey 269
** Basic Minimum Hospital and Nursing Home Care 266
Board of Trustees 264
Bylaws, Amendments to 287
Cancer Control 302
Child Health 302
Chronically Ill and the Aging 303
* Communicable Diseases' Reporting (#12) .. 321
Conservation of Hearing and Speech 305
Conservation of Vision 305
Constitution and Bylaws, Revision of 287
** Constitutional Amendment, Implementation 271
Credentials 277
* Deductible Blue Cross Insurance (#7) 318
Disaster Medical Care 308
** Distinction Between Blue Cross and Blue Shield 267
** D.O. to M.D. Conversion in California 265
Election 350
Emeritus Membership Nominations 284
* Epilepsy Reporting by Physicians (#9) ... 319
Executive Director 273
Finance and Budget 277
* Foreign Graduates in Approved Intern and Resident Training Program (#11) 321
* Foreign Medical School Graduates for House Staff Training Programs (#10) 320
** Group Health Insurance of New Jersey ... 265
* Guides for Physician-Hospital Relationships (#16) 323
Honorary Membership 280
** Hospital Service Plan In-Hospital Tests 268
* Intern Approval Program (#2, #3) ... 315, 316
** Internships in Community Hospitals 268
* JEMPAC 318
Judicial Council 272
Legislation 289
Maternal and Infant Welfare 306
Medical Defense and Insurance 280
Medical Education 282
** Medical-Legal Testimony 270
Medical Service Administration 325
** Board of Governors Nominations 266
Medical Services 297
Medical Student Loan Fund 282
Medical-Surgical Plan 328
** Board of Trustees Nominations 266
Medicare Program 325
* Membership Directory (#14) 322
Mental Health 307
Nominating Committee 350
Nursing Education 308
Occupational Health 298
* Ophthalmic Technicians (#17) 324
Physicians Placement Service 312
** Polio Immunization 271
President 258
Publication 285
Public Health 301
Public Relations 296
References Committees
Constitution and Bylaws 335
"A" 336
"B" 337
"C" 338
"D" 340
"E" 342
"F" 343
"G" 348
"H" 349
Rehabilitation 307
* Reporting of Epilepsy by Physicians (#9) .. 319
Resolutions—also indexed by subject 315
Retirement Plan for Physicians (* #18) 313, 324
Revision of Constitution and Bylaws 287
* Rotating Internship in the Community Hospital (#4) 317
Scientific Exhibits 276
Scientific Program 276
Secretary 259
* Statewide Medical Examiners' System (#1) 315
Traffic Safety 314
Transactions 1962 295
Treasurer 260
* Tuberculosis Control (#13) 322
* Union Family Health Groups (#5) 317
** Vendor Payment in Welfare Cases 269
Woman's Auxiliary Advisory 288
Workmen's Compensation 299

* Resolution
** Items from Board report

PRESIDENT

Louis S. Wegryn, M.D., Elizabeth

(Reference Committee "A")

As probably my predecessors in office all came to discover, the year now closing has proved to me that the office of president of The Medical Society of New Jersey must be experienced to be appreciated. No one who lives through his term of office can fail to emerge with anything but heightened respect for those who served before him. As its parting benefaction, the presidency affords a man a sense of satisfaction that he has enjoyed all the honors and has managed somehow to acquit himself of all the responsibilities and obligations which the office imposes.

I, for one, lay down the presidency with a heart deeply grateful for the constant cooperation and unfailing courtesies so consistently accorded me as your representative. I leave the office with the consciousness that not as much has been attained as I dreamed might be attained, but with the balancing realization that we have gone forward together in the service of our ideals and in the furtherance of our purpose.

The Medical Society of New Jersey is a live entity in a dynamic and changing world. For that reason it can never expect to have met and disposed of its problems and challenges—not while it yet lives. And for the good that it has achieved and for the greater good that it can accomplish, I am sure that we all cry "Long live the Society" and dedicate ourselves to renewed fervor and redoubled efforts.

It is gratifying to me to report, as it was satisfying to me to discover, that through the year of my service the sharp winds of political and socio-economic controversy seemed to diminish in intensity. About the time of my taking office they were blowing with gale force. I was relieved to find that we weathered their buffeting buoyantly, and through the year we were exposed to only occasional gusts. This was probably due in large part to the transfer of governmental concern from the alleged critical needs of the elderly to the clamorous reality of the Cuban crisis and the awful and imminent danger of war.

We had other areas of concern to engage us, however, dealing with the general business of the Society and the activities of our more than forty committees. We continued the constructive and very helpful activities of our committees of liaison with other professional organizations, particularly the New Jersey Hospital Association, New Jersey Pharmaceutical Association, New Jersey State Nurses Association, New Jersey Bar Association, and the New Jersey State Dental Society.

Likewise we maintained intimate contact with the American Medical Association. We were represented, of course, at the annual meeting in Chicago and at the clinical session in Los Angeles. But we were also represented officially at the AMA's Public Relations Institute, Mental Health Congress, Conference on Mental Health, Regional Conference on Aging, Disaster Medical Care Conferences, Congress on Occupational Health, and Medico-Legal Symposium.

With the agencies of State government we maintained our established contacts and initiated a few new ones. The list of those within the State with whom we met in behalf of the Society includes the Governor, the Attorney General, representatives of the Supreme Court and of administrative agencies of the court, representatives of the State Departments of Health, Institutions and Agencies, Education, and of the Divisions of Rehabilitation, Motor Vehicles, and Welfare Services. I am happy to be able to assure you that in all these contacts we were met with attitudes of courtesy and cooperation that were very encouraging to us all.

I cite the establishment and commendable activity of the Subcommittee on Physician-Hospital Relationships as one of the innovations of the year especially worthy of remark. It is my hope that in consequence of the good work of this committee, and of the Council on Medical Services to which it is attached, we will be able to formulate a policy of understanding and cooperation that will achieve and insure the continuance of new harmony in physician-hospital relationships in New Jersey, with benefit to patients, physicians, and hospitals alike. The work of this committee is really just getting under way, and in the fu-

ture will, we expect, be shared with the representatives of ancillary professional groups and of the hospitals of New Jersey.

Looking back on the year, I find that I am a much more widely acquainted, informed, and travelled man than I was when I took office. I can estimate my miles of travel as about 20,000, but I cannot venture to say how many endless hours I spent in meetings and conferences of all kinds. But I was never alone; devoted officers and members of the Society were always with me, giving of their time and counsel without stint, in order to do their willingly assumed duty to the public, the profession, and all of you of The Medical Society of New Jersey.

It was a year that I shall never forget, for the lessons I learned of the idealistic devotion and of high service and for the delights of friendly good will which I everywhere enjoyed. For all the experiences of the year, for the inspiration of working with you for our shared ideals, for the exemplary devotion to duty and generous unselfishness of all my fellow officers and of our gifted and faithful staff, my enduring thanks.

Approved (page 336)

SECRETARY

Marcus H. Greifinger, M.D,. Newark

(Reference Committee "A")

The office of the Secretary has continued its usual routines primarily involving correspondence, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the current administrative year the Secretary attended the annual meeting of the American Medical Association in New York City, as well as the clinical meeting in Los Angeles—serving in a dual role as the Secretary and an AMA Delegate. At state level, the Secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

MEMBERSHIP

(as of December 31, 1962)

Active:	Paid	6,143	
	Exempt	309	6,452*
Associate:	Paid	436	
	Exempt	48	484*
State Emeritus			146
State Honorary			4
New and reinstated members:			
	Active	215	
	Associate	281	496
Transfers within the state			38
Transfers out-of-state and resignations			46
Members deceased			95
Members dropped:			
	Active (non-payment of dues)	49	
	Associates not advanced to active status	21	70

*Adjusted for Transfers Out-of-State, Resignations, and Deaths.

AMA MEMBERSHIP

5,822 members of The Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates continued to total six delegates—one for each thousand members, or fraction thereof.

MEMBERSHIP DIRECTORY

All copies of the 5th edition of the *Membership Directory*, 1961-62 issue, have been distributed. The Special Committee on Membership Directory on August 26, 1962 postponed further publication of the *Directory* for at least one year or until such time as the New Jersey Bell Telephone Company completes its conversion to the numbered dial system throughout the State.

The committee also agreed to the following:

1. That a list of county medical society office addresses be included in the *Directory*.
2. That the listing of MSNJ officers not be included in the *Directory* in the future. Such a listing is incorrect after the first year following publication, since the *Directory* is normally published every two years.
3. That a list of Honorary members be included in the *Directory*.
4. That Emeritus and Associate members be identified as such in future editions.
5. That the alphabetical list of hospitals be moved from the front to the rear of the *Directory* immediately preceding the community hospital listings.

Approved (page 336)

TREASURER

Daniel F. Featherston, M.D., Asbury Park

(Reference Committee "B")

The administrative and fiscal year of MSNJ is June 1—May 31. The following financial report covers the business transactions in the office of the Treasurer for the past twelve months, representing transactions of one month in the fiscal year 1961-62 and eleven months in 1962-63—in accordance with the suggestion that the report cover twelve months even though two fiscal years are represented.

This report, prepared and submitted by the auditor, covers the accounts from May 1, 1962, through April 30, 1963:

BALANCE SHEET — APRIL 30, 1963

ASSETS

Cash:		
First Trenton National Bank:		
General Checking Account	$ 49,175.30	
Executive Office Revolving Account	10,000.00	$ 59,175.30
Savings Accounts:		
Bloomfield Savings Bank, Bloomfield	$ 10,000.00	
First Camden National Bank and Trust Company	10,000.00	
First Merchants National Bank, Asbury Park	10,000.00	
First National Bank of Westville	10,000.00	
The Howard Savings Institution, Newark	10,000.00	
The Morris County Savings Bank, Morristown	8,335.83	
The Montclair Savings Bank, Montclair	10,000.00	
Plainfield Trust Company, Plainfield	6,020.29	74,356.12
Savings and Loan Accounts:		
Guardian Savings and Loan, Atlantic City	$ 10,000.00	
Midtown Savings and Loan, Newark	10,000.00	
Monroe Savings and Loan, Newark	10,000.00	
Police Savings and Loan, Newark	10,000.00	
Roma Savings and Loan, Trenton	10,000.00	50,000.00
Total Cash		$183,531.42
Accounts Receivable		8,833.01
Inventory—Maternal Welfare Record Books (at cost) (contra)		3,743.75
Investments—U. S. Savings Bonds and Treasury Bills		154,244.95
Land, Buildings and Equipment (contra)		152,104.60
Loans to Medical Student Loan Fund		53,500.00
Interest Accrued on Investments		302.00
Total Assets		$556,259.73

LIABILITIES, RESERVES, AND SURPLUS

Employees' Payroll Deductions Payable	$ 1,465.14
Assessments Collected, Applicable to 1963-64 Fiscal Year	138,047.11
Unexpended Budget Reserve, 1962-63 Fiscal Year	50,548.25
Annual Meeting Reserve	27,936.91
AMA-ERF Assessments	284.69
Other Liabilities	59.43
Land, Buildings and Equipment Reserve (contra)	152,104.60
Maternal Welfare Record Books Reserve (contra)	3,743.75
History Reserve—1966	2,500.00
Membership Directory Reserve	217.93
Surplus (Note 1)	179,351.92
Total Liabilities, Reserves and Surplus	$556,259.73

Note 1. Includes $61,597.00 of funds committed for transfer on loan without interest to the Medical Student Loan Fund pursuant to resolution of Board of Trustees adopted January 15, 1961.

STATEMENT OF RECEIPTS AND DISBURSEMENTS

May 1, 1962 — April 30, 1963

RECEIPTS — GENERAL FUND

Cash Balance, May 1, 1962				$166,663.88
Assessments:	State Dues	AMA Dues	AMA-ERF	Total
Atlantic County	$ 7,446.63	$ 7,860.00	$ 119.19	$ 15,425.82
Bergen County	27,211.65	23,160.00	241.58	50,613.23
Burlington County	5,101.70	5,455.00	44.97	10,601.67
Camden County	14,540.00	15,647.50	99.97	30,287.47
Cape May County	1,666.66	1,680.00	68.33	3,414.99
Cumberland County	3,545.83	3,465.00	7.49	7,018.32
Essex County	58,980.64	57,235.00	425.80	116,641.44
Gloucester County	2,772.46	2,860.00	21.67	5,654.13
Hudson County	22,249.15	21,797.50	250.82	44,297.47
Hunterdon County	1,839.99	2,025.00		3,864.99
Mercer County	16,546.63	17,927.50	247.50	34,721.63
Middlesex County	13,064.97	14,010.00	68.31	27,143.28
Monmouth County	11,070.76	9,470.00	255.82	20,796.58
Morris County	10,879.95	11,590.00	106.66	22,576.61
Ocean County	3,418.32	3,625.00	65.83	7,109.15
Passaic County	22,196.60	18,997.50	83.33	41,277.43
Salem County	1,720.00	1,935.00		3,655.00
Somerset County	3,829.96	4,020.00	23.34	7,873.30
Sussex County	1,283.32	1,190.00	183.34	2,656.66
Union County	23,146.67	25,065.00	93.27	48,304.94
Warren County	1,636.65	1,710.00	8.34	3,354.99
AMA Refunds		690.00		690.00
Total Assessments	$254,148.54	$251,415.00	2,415.56	$507,979.10

Journal Advertising (Net)	$ 39,059.15	
Annual Meeting Exhibits	21,024.33	
Interest Income	6,575.89	
Sale of Maternal Welfare Books	901.25	
Employee Payroll Deductions	158.76	
Refunds of Budget Expenses 1962-63	1,097.29	
AMA Dues Collection	1,954.84	
Membership Directory	582.90	
Prior Year Dues, Assessments	70.00	
Proceeds from Sale of Investments (at cost)	168,930.41	
Pension Plan Credit	2,324.76	
Miscellaneous Receipts	434.97	
Total Receipts		$751,093.65
Total		$917,757.53

DISBURSEMENTS — GENERAL FUND

Budget Accounts:

A- 1	Executive Salaries	$ 44,236.56
A- 2	Executive Office Salaries	58,888.33
A- 3	Executive Office Expenses	3,007.32
A- 4	Executive Travel	2,400.03
A- 5	House Maintenance	16,288.25
A- 6	Treasurer	3,806.79
A- 7	Finance and Budget Committee	12.15
A- 8	Secretary	389.01
A- 9	Salary Taxes	3,228.55
A-10	Insurance	3,796.24
A-11	House Reserve	1,770.04
C- 2	Council on Legislation	4,189.20
C- 3	Council on Public Health	2,347.81
C- 4	Council on Public Relations	6,255.63
C- 5	Council on Medical Services	941.44
D- 1	President and Presidential Officers	11,086.38
D- 2	AMA Delegates	6,504.62
D- 3	Woman's Auxiliary	3,862.41
D- 4	Committee on Medical Education	10.02
D- 5	Conference Groups	78.75
D- 6	Credentials, Membership, Directory, and Physicians Placement	736.33
D- 7	Disaster Medical Services	151.29
D-10	Blood Bank Commission	250.00
D-11	Medical Defense and Insurance	592.86
E- 1	Board of Trustees	5,187.63
E- 2	Contingent	8,539.26
E- 3	Judicial Council	514.55
E- 4	Legal	5,440.66
E- 6	Medical Student Loan Fund Contribution	5,000.00
	Total Budget Accounts	$199,512.11
	Transfer to Medical Student Loan Fund from Annual Meeting Reserve	$ 2,103.07
	Journal Publication and Expenses	49,007.60
	Annual Meeting Expenses	17,026.51
	Transfer to Medical Student Loan Fund	32,759.20
	AMA Dues Remitted	278,985.00
	Assessments Refunded	1,343.29
	American Medical Association—Education Research Foundation	31,786.59
	AMA Dues Collection	1,911.16
	Purchase of U.S. Treasury Bills	119,244.95
	Miscellaneous Disbursements	546.63
	Total Disbursements	$734,226.11
	Cash Balance, April 30, 1963	183,531.42
	Total	$917,757.53

MEDICAL STUDENT LOAN FUND

ASSETS

Cash	$ 58,222.74
Notes Receivable—87 loans to 64 Medical Students	80,825.35
Investments—at cost	14,767.94
Total Assets	$153,816.03

JOURNAL

(Cash Basis)

May 1, 1962 — April 30, 1963

Cash Receipts:		
Advertising—State Medical Journal Advertising Bureau	$ 32,021.65	
Advertising—Local	13,093.80	
Subscriptions and Extra Copies	468.46	
State Medical Journal Advertising Bureau Rebate	722.49	
Decrease in Accounts Receivable	1,099.53	
Total Receipts		$ 47,405.93
Cash Disbursements:		
Discount and Commissions—State Bureau	$ 5,124.18	
Discounts—Local	6.78	
Commissions—Local	2,828.22	
Bad Debts	387.60	
Publication Costs (11 Months)	47,975.95	
Journal Office Expenses	526.78	
Journal Travel	445.28	
Publication Committee Expense	59.55	
Total Disbursements (Note 1)		$ 57,354.38
Excess of Disbursements over Receipts		$ 9,948.45

Note 1. Exclusive of administrative salaries charged to appropriations provided therefor in the general budget.

Accounts Receivable of the Medical Journal at April 30, 1963 — Total $ 8,833.01

LIABILITIES AND FUND BALANCE

Loan from General Fund	$ 53,500.00
Fund Balance	100,316.03
Total Liabilities and Fund Balance	$153,816.03

Fund balance includes $6,042.00 designated as the A. Barker Kump Memorial Grant and $1,430.00 as the Joseph E. Mott Memorial Grant.

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS

May 1, 1962 — April 30, 1963

Cash Balance, May 1, 1962		$ 4,627.26
Receipts:		
Budget Appropriation from General Fund	$ 5,000.00	
Interfund Transfers	32,759.20	
Contributions	6,604.98	
Transfer from Annual Meeting Reserve	2,103.07	
Interest on Notes Receivable	95.25	
Collections on Notes Receivable	1,650.00	
Investments Redeemed	42,757.50	
Interest on Investments	1,705.62	
Total Receipts		$ 92,675.62
Total		$ 97,302.88
Disbursements:		
Loans to Medical Students	$ 23,500.00	
Purchase of Investments	15,580.14	
Total Disbursements		$ 39,080.14
Cash Balance, April 30, 1963		$ 58,222.74

Approved (page 337)

BOARD OF TRUSTEES

Samuel J. Lloyd, M.D., Chairman, Trenton

(Reference Committee "A")

The Board of Trustees regularly has dealt with general matters brought to its attention—correspondence and resolutions from members, component societies, and outside organizations; appointment of representatives to local, state, and national meetings of concern to this Society; consideration of and action on the reports and recommendations of the several standing committees and administrative councils and their special committees; cooperation with the departments of the State government, and with the allied professions.

As has been the custom, the report of the Board of Trustees will highlight only the major business considered and acted upon during the year and will cover such items as are not reflected elsewhere in the reports. The majority of the Board's activities of the year have been published in THE JOURNAL. Eleven regular meetings will have been held between annual meetings. In addition, the numerous Board committees have been called upon to meet frequently.

In the majority of instances, the Board's activities—as will be noted from the following items—have been concerned with specialized subjects which are referred to other reference committees for consideration in connection with the main subjects to be dealt with by those reference committees.

In order to set forth the attitude and opinions of the Board on matters to be considered by the reference committees, one or more members of the Board of Trustees have been assigned to each reference committee.

Approved (page 336)

AMA LISTS OF PHYSICIANS

(Reference Committee "A")

The resolution on this subject (#10), received and considered by the 1962 House of Delegates, was not adopted by the House for the reason that it was not clearly stated whether the list mentioned was the official AMA Directory or a specialized list; and the House directed that the resolution be called to the attention of the Board of Trustees and AMA Delegates and Alternate Delegates for further investigation and clarification.

The following information was received from the Executive Vice-President of the AMA, copy of which was supplied to the sponsor of the resolution, the Mercer County Medical Society:

First, I should like to make it clear that there are many lists of physicians which are compiled and used by private entrepeneurs —they obtain these names and addresses from telephone directories and other sources. The existence and use of these lists means that a significant portion of the professional mail directed to physicians does not involve the official list maintained by the American Medical Association.

For many years, the AMA has maintained a directory of all physicians residing in the United States and its possessions. This list forms the basis for our membership records, for addressing official communications, and for mailing JAMA, the Specialty Journals, the AMA News, and Today's Health to physician members.

Also, it has long been the policy of the AMA to make this list available to outside parties who have a legitimate interest in communicating with physicians; in so doing, we are guided by the following policies:

1. All such communications must be germane to the practice of medicine in its scientific or socio-economic aspects, or of interest to the physician as a consumer.

2. All such communications must be free of contents which tend to mislead, misinform, or deceive physicians.

3. At the request of any physician, the American Medical Association will exclude his name and professional mailing address from lists made available to outside parties.

4. Outside parties using mailing lists furnished by the American Medical Association will be charged a service fee sufficiently large to reimburse the AMA for the costs incurred in compiling these lists and in keeping them current.

5. The American Medical Association will waive the usual service fee when the organization communicating to physicians is a professional medical or allied association and is recognized as such by the AMA.

Approved (page 336)

D.O. TO M.D. CONVERSION IN CALIFORNIA

(Reference Committee "A")

As an accredited medical school the California College of Medicine—converted last year from the California College of Osteopathy—graduated its first class with M.D. degrees in June 1962.

By special statute enacted by the California Legislature, the M.D. degree was granted in July, 1962, to 2,100 graduates of osteopathic schools and holders of the D.O. degree. This new M.D. degree is valid in California; it is not exportable. In other states the validity of the degree depends entirely upon the licensing laws of such states. The AMA has recognized the holders of the new M.D. degree for membership in the AMA.

The Committee on Credentials requested guidance as to the eligibility of holders of the new M.D. degrees for membership in MSNJ.

The State Board of Medical Examiners was requested for an opinion as to the validity in New Jersey of the California M.D. degree issued to D.O.'s. The State Board replied:

> The action of the State Board of Medical Examiners of New Jersey, in its ruling of April 11, 1962, is that the doctor who graduates from the California College of Medicine in 1961 and is currently taking his internship to be finished in June 1962, if he were to apply for licensure by examination in New Jersey, would be licensed as a Doctor of Osteopathy, if he were successful in the examination. If he is a graduate of the California College of Medicine in June 1962 or subsequently, and receives his M.D. degree because of the changes in California, he would take an examination and if successful, be licensed as an M.D.

The Board then submitted a hypothetical question to the State Board of Medical Examiners—as to what will be the attitude of the State Board to admitting to licensure in New Jersey the holder of an M.D. degree by conversion from the California College of Medicine—to which the State Board replied:

> The Board will not consider that any special program given by the California College of Medicine under a special program of the College, operating between July 1, 1962 and September 30, 1962, qualifies the graduate as an M.D., since he has not had four years in an approved medical school.
>
> If he were to seek permission to take an examination, the ruling of the Board is, that if he graduated prior to 1962, he would be permitted to take the examination as a D.O., if he fulfilled all the other requirements.

Following consideration of the report of the special committee appointed to study this matter, it was the action of the Board of Trustees that the following recommendation be approved, but that its effectuation be deferred until after the 1963 House of Delegates has considered the recommendation and acted upon it.

RECOMMENDATION

That any person fully licensed as a physician and surgeon by the State Board of Medical Examiners of New Jersey, licensed originally as holding a D.O. degree but who subsequently converted the D.O. degree to an M.D. degree through the California College of Medicine under its special program terminated on September 20, 1962, be considered to have an M.D. degree acceptable to this Society, provided that such person agree in writing to use the M.D. degree exclusively hereafter.

Recommendation not accepted:

(1) Until such time as the official body which we accept for the accreditation of medical schools approves the California College of Medicine specifically in its action of granting the M.D. degree to 2,100 graduates of osteopathic schools in July 1962; and

(2) Until the State Board of Medical Examiners qualifies one or more of these graduates as an M.D.

Suggested that the Board of Trustees and Society's Legal Counsel enter into consultation prior to taking any further steps aimed at implementing the recommendation. (page 336)

COMPLAINT OF GROUP HEALTH INSURANCE OF NEW JERSEY

(Reference Committee "C")

Last spring a civil action was filed in Superior Court by Group Health Insurance of New Jersey—a newly organized medical service plan similar to Blue Shield—against the Commissioner of Banking and Insurance and the Attorney General. The action asked the Court to determine the constitutionality of certain sections of the Medical Service Corporations Act, namely (1) the requirements that nominations of Trustees of any medical service corporation must be "approved by a recognized medical society or professional medical organization having not less than two thousand members holding licenses to practice medicine and surgery, and which has been

incorporated for not less than ten years; and, (2) the requirement—as a condition precedent to the issuance by the Commissioner of a certificate of authority to solicit subscribers and enter into contracts—that 51 per cent of the eligible physicians in any county be enrolled as participating physicians.

The Attorney General moved to have Medical-Surgical Plan of New Jersey and The Medical Society of New Jersey joined as party defendants, although neither volunteered to be so joined. The motion was returned and an Order was signed which directed that the Complaint be amended to include MSP and MSNJ as party defendants, and that Summons and Complaint be served upon both new parties.

The answer in this case, served and filed for MSNJ by legal counsel, in effect was tantamount to a general denial of the allegations.

In response to legal counsel's request for directions as to how vigorously MSNJ should participate in the defense of this case, after extended study based upon the fundamentals of the case and the appellant's brief, the following conclusion was reached:

> We must pursue our efforts to retain the requirements of present law as necessary and desirable in protection of the public interest through insisting upon adequate enrollment of participating physicians in all counties in order to safeguard the fulfillment of the coverage offered in the medical service corporations' insurance contracts. We have contended, and still do, that the best way to encourage the necessary adequate participation on the part of physicians is to establish boards of trustees which have the confidence of the members of the medical profession. In the absence of such confidence, it is the expectation that it would be difficult, if not impossible, to enroll a sufficient number of physicians and surgeons in the counties of New Jersey to service the insurance coverage proposed.
>
> In passing, the members of the Board indicated that in their view GHI of New Jersey is, as it expressly declares more than once in its brief, an indemnification insurance organization and that, therefore, in aspiring to be permitted to incorporate as a medical service corporation it seeks to go beyond the bounds of its purposes and capabilities.

Approved (page 338)

MSA BOARD OF GOVERNORS—NOMINATIONS

(Reference Committee "C")

The following nominations for membership on the Board of Governors of Medical Service Administration of New Jersey for 1963-64 were approved by the Board of Trustees of MSNJ and are referred to the House of Delegates for action:

Irving P. Borsher, M.D.
Harry N. Comando, M.D.
Arthur W. Lunn
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.

Approved (page 339)

BASIC MINIMUM HOSPITAL AND NURSING HOME CARE

(Reference Committee "C")

The 1962 House of Delegates referred to the Board of Trustees for study and action, and directed that the Board report the results of its study and action to the next annual meeting, the resolution (#23) on Basic Minimum Hospital and Nursing Home Care. The resolution called for a comprehensive insurance program for minimum basic hospital care and nursing home care for the entire population with premium costs apportioned accordingly; supplemented by the government (for those with an income below $4,500) from monies made available by collection of income tax revenues. To supplement this plan, private insurance companies would be urged to write medical and surgical and extended hospital insurance.

Following study and discussion of this resolution, it was the action of the Board of Trustees that the resolution be received and noted on the basis that many of its stipulations involve Federal governmental agencies and are impossible for the Board to implement.

Approved (page 338)

MSP BOARD OF TRUSTEES—NOMINATIONS

(Reference Committee "C")

Nominations for membership on the Board of Trustees of Medical-Surgical Plan were received from the Plan Trustees and considered by the Board of Trustees of MSNJ. The Board noted the recommendation of Reference Committee "C" which was adopted by the 1962 House of Delegates: "That physicians from South Jersey and general practitioners be included in future lists of nominees." It was the opinion of the Board that the nomination of Dr. Tyler fulfilled the request for more representation from South Jersey on the MSP Board of Trustees.

The following nominations were approved by the Board of Trustees, and are referred to the House of Delegates for action:

Three-Year Term (1963-1966)	Type of Practice	Member of Component Society
Charles W. Barkhorn, M.D.	Otolaryngology	Essex County
Irving P. Borsher, M.D.	Internal Medicine	Essex County
F. Clyde Bowers, M.D.	Internal Medicine	Morris County
Robert G. Boyd		
Charles L. Cunniff, M.D.	Internal Medicine	Hudson County
Andrew P. Dedick, Jr., M.D.	Radiology	Monmouth County
Gustave E. Wiedenmayer		

Two-Year Term (1963-65) unexpired term of Mr. David L. Yunich, resigned.

Charles O. Tyler, M.D.	Pediatrics	Camden County

For the record, the following are the remaining members of the Board of Trustees:

Joseph P. Donnelly, M.D.	Ob. and Gyn.	Hudson County
Joseph L. Echikson, M.D.	Internal Medicine	Essex County
Jerome G. Kaufman, M.D.	Internal Medicine	Essex County
Joseph M. Keating, M.D.	Surgery	Passaic County
Elton W. Lance, M.D.	Surgery	Union County
Samuel J. Lloyd, M.D.	Surgery	Mercer County
Jesse McCall, M.D.	Internal Medicine	Sussex County
Duane E. Minard, Jr.		
Glennis S. Rickert, M.D.	General Practice	Morris County
Royal A. Schaaf, M.D.	Surgery	Essex County
Rudolph C. Schretzmann, M.D.	Ob. and Gyn.	Bergen County
Edward W. Sprague, M.D.	Surgery	Essex County
John S. Thompson		
Thomas J. White, M.D.	Internal Medicine	Hudson County
Jerome G. Kaufman, M.D.	Internal Medicine	Essex County

President, The Medical Society of New Jersey

With the exception of F. Clyde Bowers, M.D., whose resignation has been accepted, the other nominees were approved. The reference committee was also informed that Glennis S. Rickert, M.D. had also resigned and that his resignation had been accepted; and that with the acceptance of the resignations of Dr. Bowers and Dr. Rickert four vacancies exist on the MSP Board of Trustees. (page 339)

DISTINCTION BETWEEN BLUE CROSS AND BLUE SHIELD

(Reference Committee "C")

In reply to resolution #9, adopted by the 1962 House of Delegates, the President of Hospital Service Plan of New Jersey wrote:

Considering the statements made in the preamble of the resolution, a press release was issued by the Blue Cross Plan for publication April 12, 1962, in which it was pointed out that the rates of New Jersey Blue Cross Plan only were increased. The press release further points out that the administrative expense of New Jersey hospitals, chiefly payroll, was a basic reason for the necessary increase, and specifically credits the Medical profession with cooperation in endeavors to keep the costs of hospitalization within bounds. This was gone into even further during the public hearing before the Commissioner of Banking and Insurance on April 12th.

As to the desirability of separate billing for Blue Cross and Blue Shield, we respectfully point out that the economical operation of both Plans would be adversely affected by such a step.

Installation of separate billing would be a costly operation, in that it would necessitate the acquisition of new mechanical equipment to enlarge the volume of printed characters in the Electronic Data Processing system. For accounts which have not yet been converted to the Electronic Data system's tape method, additional punch cards would be required. Greater storage space and an augmented clerical staff would be needed to install and maintain a dual billing system such as that suggested by the resolution. The end result would be additional cost to the subscribers of both Blue Cross and Blue Shield.

In an effort to effectuate the purpose of the resolution, we have evolved a method of acquainting each individual subscriber with the fact that Blue Cross and Blue Shield are separately purchased, through means of a notice which specifies the rates for each class of contract under each Plan. We believe that the general distribution of

this card along with bills to our subscribers will clarify any misunderstanding.

A copy of the above reply was supplied to the Mercer County Medical Society, sponsor of the resolution.

Approved (page 338)

HSP IN-HOSPITAL TESTS

(Reference Committee "C")

Resolution #12, also adopted by the 1962 House of Delegates, was transmitted to Hospital Service Plan of New Jersey. The Plan President replied:

> We agree, as stated in the approval appended to Resolution #12, that it is highly desirable that physicians discuss the Blue Cross contract limitations with their patients before ordering examination and services.
>
> The proposal, by the Camden County Medical Society, that the attending physician be contacted for his opinion of the necessity of questionable tests prior to claim determination, is not practical, and we believe unnecessary, in view of our existing procedure.
>
> If, following the review procedure, the attending physician wishes to protest the Plan's determination, our Medical Advisors will review the case again, and if they are still of the same opinion, an offer is made to the attending physician to send the case to The Medical Society of New Jersey Advisory Committee to review Medical-Surgical and Hospital Service Plan disputed claims.

To facilitate physicians' discussion with their patients of Blue Cross contract limitations before ordering examinations and services, a statement covering the contract provisions and interpretations was prepared by HSP and mailed over the name of the President of MSNJ to the membership in early April.

Approved (page 338)

INTERNSHIPS IN COMMUNITY HOSPITALS

(Reference Committee "D")

As directed by resolution #11, adopted by the 1962 House of Delegates, a resolution was introduced by the New Jersey delegation at the 1962 AMA annual meeting in Chicago. The resolution called upon the AMA to recognize the dangers to medical graduates, community hospitals, and the public at large inherent in the present practices of medical centers to pressure medical graduates to intern in medical centers, and to take the necessary steps to encourage medical graduates to intern in community hospitals of their choice.

At the recommendation of the reference committee—which considered the New Jersey resolution and a similar resolution submitted by the California delegation—the AMA House of Delegates in adopting the report of the reference committee, recorded itself as in accord with the intent of the New Jersey resolution. It declared specific approval in principle of 'the concept of the need for some experience in general practice as a prerequisite to specialty residences." The reference committee combined the "resolves" of both resolutions into one substitute resolution which the House adopted, namely:

> Whereas, the changing pattern of needs in medical care makes it imperative that medical education be productive of more doctors oriented toward general practice, therefore be it
>
> Resolved, that the American Medical Association through its Council on Medical Education and Hospitals, continue to create and recommend that medical faculties actively encourage their graduates to utilize such programs to assure an adequate supply of family physicians.

Approved (page 340)

AMA PUBLICITY ON COMPENSATION OF INTERNS AND RESIDENTS

(Reference Committee "D")

Last November the contents of the "Report on Compensation of Interns and Residents," submitted by the Council on Medical Service and the Council on Medical Education and Hospitals, for the consideration of the AMA House of Delegates at the clinical meeting were prematurely released to the newspapers prior to the convocation of the House of Delegates in Los Angeles. By direction of the Board of Trustees, the New Jersey delegation presented at the Los Angeles meeting a resolution in opposition to the Council's report and another resolution calling for a policy that future reports or proposals not be released to the press until the House has committed itself officially in connection with them. The Council's report was finally presented not for action but for study, and the New Jersey resolution of opposition was withdrawn. The second New Jersey resolution was referred to the AMA Committee on Communications.

The report on "Compensation of Interns and

Residents" is to be considered by the AMA House of Delegates at the Atlantic City meeting in June. The attention of the Board of Trustees was directed to an official memorandum of the AMA's Council on Medical Education and Hospitals issued in February to all hospital administrators of the United States, supplying three copies of an article which set forth the proposals of the council's report and suggesting that the extra copies be given to the chief of staff and chairman or president of the hospital board of trustees. In the view of the Board of Trustees the obvious purpose of the memorandum was to generate among hospital administrators and boards of governors such an attitude of strong support of the recommendation contained in the report to the House of Delegates as would improperly influence the members of the House of Delegates in their deliberations and decisions.

In the name of the Board of Trustees and of The Medical Society of New Jersey a vigorous protest was lodged with AMA officials against the memorandum, deploring the action as improper and in presumptuous disregard of the right of the AMA's House of Delegates to free and unprejudiced deliberations on all matters before it. The Board expressed the hope that no such further prejudicial releases would be made. A copy of the Board's communication was sent to the secretaries of all state societies requesting that the communication be called to the attention of their AMA delegates, for their information and possible support.

Approved (page 340)

RESOLUTION OF NEW JERSEY ASSEMBLY

(Reference Committee "E")

Resolution #20, adopted by the 1962 House of Delegates, empowered and urged the President and Board of Trustees to take any vigorous action necessary in protest against a reported action of the New Jersey Assembly which, by resolution, made an unfounded attack upon the medical profession. The reported action of the Assembly was in connection with A-755 (1962) which would forbid medical practitioners to refuse their services to a person solely because of the prospective or intended method for payment of the charge for such service.

A-755 was withdrawn shortly following the 1962 annual meeting, and on this basis, the Board of Trustees agreed that no action was necessary in connection with resolution #20.

Approved (page 342)

1962 ANNUAL MEETING PUBLICITY

(Reference Committee "E")

At the closing session on May 14, 1962, the House of Delegates took the following action:

> That, in order to provide adequate and complete information to the public concerning the policies adopted by The Medical Society of New Jersey at this convention, the Board of Trustees be empowered and urged to purchase newspaper space or other means of disseminating public information within their discretion and judgment if the actions of this convention are not favorably presented.

Noting the action of the House, it was the consensus of the Board of Trustees—at its reorganization meeting on May 15, 1962—that the publicity in the morning papers on the actions of the House of Delegates was fair, and that newspaper advertising should not be undertaken at that time. A communication was sent to the component societies over the signature of the President informing the counties that, "In view of the generally favorable and adequate reflections of the House of Delegates in the press, the Board has decided that it will not be necessary at this time to launch a paid advertising publicity campaign."

Two resolutions on the Kerr-Mills Act (#14 and #19) were adopted by the House and referred to the Board of Trustees for any possible implementation. The Board agreed that the 1962 annual meeting publicity had taken care of these referrals and that no further action was necessary.

Approved (page 342)

VENDOR PAYMENTS IN WELFARE CASES

(Reference Committee "F")

Resolution #7, adopted by the 1962 House of Delegates, was submitted to the Division of Welfare, State Department of Institutions and Agencies. The following reply was received from the Medical Director of the Division, copies of which were supplied to the sponsor, the Burlington County Medical Society, and to the members of the Subcommittee

on Public Medical Care of the Council on Medical Services for their information:

It is the desire of the Division of Welfare to strive for the utmost in simplicity and practicability as to program content and required forms, consistent with the need to provide useful information for operating statistics, auditing and accountability of expenditures from public funds.

The advice, counsel and active participation of the Subcommittee of the Council on Medical Services are most welcome in the development of an organized health care program for public assistance recipients and those persons eligible for care through other public welfare services programs.

Reply Accepted (page 343)

MEDICAL-LEGAL TESTIMONY

(Reference Committee "F")

The New Jersey Supreme Court's Committee on Expert Medical Testimony was authorized to re-explore the problems presented by the so-called medical malpractice or professional liability cases, originally suggested by the special committee of The Medical Society of New Jersey. A plan for the use of a professional liability panel in such cases, devised previously by the joint group, was reviewed and studied together with pertinent material supplied by the Society's special committee.

The report of the joint committee was reviewed by the Committee on Medical Defense and Insurance which suggested slight amendment. The Board of Trustees approved the amended plan and directed that a copy be forwarded to the chairman of the Supreme Court's committee. The Board noted that the draft of the plan cannot be considered final, and that it is subject to amendment and/or revision before the Supreme Court can put it into final rule—such amendment and/or revision to be agreed upon by all parties concerned.

The Supreme Court's committee recommended to the New Jersey Supreme Court the establishment of professional liability panels to evaluate alleged medical negligence claims, that the panels function on an experimental basis for an indefinite period, and that the experiment be on a state-wide basis rather than be limited to a few counties. The committee of the Court stated that, administratively, it will be necessary that doctors and lawyers on the subpanels be chosen by the Administrative Director of the Courts from the various geographic sections of the state, with due consideration as to their county seats. The Medical Society, for instance, is sub-divided into five districts and the doctors would prefer that they sit on subpanels only in their own district.

The opening paragraph of the outline on the proposed professional liability panel states: "It would appear to be in the common interest of both the medical profession and the legal profession that some procedure be devised (1) to discourage baseless professional liability cases and (2) make expert medical testimony available in those professional liability cases where there is a reasonable basis for the claim." The concluding paragraph of the outline states: 'Since a plan such as here suggested can only operate on a voluntary basis, if it is to be successful it is essential that it receive the strong support not only of the medical and legal professions but of the public as well. This will require a considerable public relations effort to explain the purposes and operations of the plan."

The proposed plan was submitted to the Supreme Court. Subsequently the chairman of the Court's Committee was informed by the Administrative Director, "While, because of the pressure of other matters, the Supreme Court did not have an opportunity to carefully study and discuss your report it did feel that the recommendation, which is similar to the one made by the Committee two years ago, has a great deal of merit but that its success depends completely on the extent of the cooperation extended by the plaintiffs' attorneys and by the doctors. In this regard it was most pleased to note that the recommendations of the Committee were approved by the Board of Trustees of The Medical Society of New Jersey. Accordingly, the Supreme Court suggests that your committee engage in some missionary work to secure the interest and cooperation of the members of the bar in an effort to obtain their endorsement of the plan . . ."

Through the chairman of the Court's Committee the bar associations of the several counties were requested to endorse the proposed plan and to afford an opportunity for a doctor and a lawyer member of the committee to appear before each association and submit the plan for consideration. These appearances before the local bar associations are in process.

Received as a progress report. Recommended that the appearances of a physician and a lawyer member of the committee before County Bar Associations be implemented at the earliest convenience. (page 343)

POLIO IMMUNIZATION

(Reference Committee "G")

The Board received a recommendation from the Special Committee on Child Health, an alternate recommendation from the Council on Public Health, and a communication from the Commissioner of the State Department of Health—all concerning polio immunization and the use of the Salk/Sabin vaccines. Because of the controversy at that time on the Sabin Type III vaccine, the Board deferred action until a later meeting.

Subsequently, the Board of Trustees took the following action:

That component societies be encouraged to exercise leadership in polio immunization in cooperation with local Boards of Health and the State Department of Health in a program best suited to their needs.

Approved (page 348)

IMPLEMENTATION OF CONSTITUTIONAL AMENDMENT

(Reference Committee on Constitution and Bylaws)

Inquiry was received by the Board of Trustees as to the intent of the amendment to Article IV, Section 4 of the Constitution (adopted by the 1962 House of Delegates) affecting the apportionment of delegates—1 delegate for each 20 members or major fraction thereof—for proper implementation by the component societies. The following report and recommendations of the special committee, appointed by the Board to consider the intent of the amendment, were approved by the Board and the component societies so notified:

The committee agreed on the following points:

1. By use of the word "shall" throughout the amended paragraph, the regulation is mandatory.
2. Since the amendment did not include a specific effective date, it became effective immediately upon its adoption.
3. Stipulation of the number of delegates to which a component society is entitled is by regulation of the State Society; and development of the body of delegates in the proper number is the business of each component society.

The delegations of seventeen component societies will be affected by the amendment, and following discussion of several approaches to the problem, the committee agreed that the easiest solution would be for the component societies to have their delegations resign and then to re-elect in the proper number.

The committee recommended:

1. If a component society has not evolved its own method of effecting the change, and advice is desired, we suggest that the component society call for uniform resignations of its entire delegation, and then follow-up with re-election of the new delegation in the proper number in conformity with the amended provision of the Constitution.
2. To let the component societies know that the problem is not too complex, particularly in view of the fact that some delegates do not attend meetings year after year, we suggest that an absentee record be sent to the counties with indication that, upon request to the Executive Offices, they can obtain the names of the absentee delegates (if they have not kept the attendance records sent to them at the close of each annual meeting).

To avoid confusion and to report accurately the number of delegates to which each component society is entitled, under the new Constitutional provision reducing the apportionment of delegates, legal counsel was requested to supply an interpretation of the word "recorded" as used in the Bylaws, Chapter I, Section 2, paragraph (c), which reads: "Immediately after December 31 of each year, the Secretary of this Society shall notify each component society of the number of delegates to which it is entitled during the next suceeding year in the House of Delegates, based on the number of active members recorded in the office of the Secretary on that date; . . ."

The following opinion of legal counsel was approved as representing the official interpretation by the Board of Trustees of this Bylaws provision, and the Board directed that the number of county delegates be allocated accordingly:

The word "recorded" is interpreted to mean of record on the 31st of December in the office of the Secretary of MSNJ. The Secretary's records will reflect a certain number of active members for each component society, as a result of information gained by the Secretary directly or indirectly. This number will exclude members who are deceased as of that date, members who have resigned as of that date, members who have transferred to another state, and members who have transferred to another county within the state as of that date.

With regard to transfers within the state, such transfers must be completed prior to December 31 for the physician to be counted in the membership of the new society—that is, prior to December 31, the transferring member is accepted in the new society, and the new society has notified the State Secretary that the transferring member is now an active member of its society.

Approved (page 335)

JUDICIAL COUNCIL

E. Vernon Davis, M.D., Chairman, Camden

(Reference Committee "A")

During the past year, the Judicial Council has met regularly in order to keep its calendar current. Its agendas have been extensive, and all Councilors have been diligent in their service.

Though the Council records with satisfaction a substantial decrease in the total of complaints received, this has been an active year. Improvement in the statewide operation of the judicial mechanism has continued and perhaps in part accounts for the decrease in complaints.

Apart from its function as an appellate tribunal considering matters originally dealt with by judicial committees of component societies, the Judicial Council has the responsibility of supervising, directing, and keeping summary records of all complaints dealt with by judicial committees of component societies as matters of original jurisdiction. To accomplish this, the Council—through the cooperation of county judicial committees—receives concise reports of all cases accepted for adjudication by judicial committees and of the dispositions arrived at. From the official files of the Judicial Council, we present the following resume of its operations and those of its county judicial committees for the period extending from April 1, 1962 to March 31, 1963:

BY THE JUDICIAL COUNCIL

Official communications acted upon		25
Appeal hearings granted		5
	Disposed of	3
	Pending	2
Formal opinions rendered		1
	Ethical acceptability of physicians' charging or retaining fees for, medical services rendered the dependents of other physicians (presented in full as an appendix to this report)	

BY JUDICIAL COMMITTEES

Complaints reported as disposed of		55
Alleging:		
	Dissatisfaction concerning fees	36
	Unprofessional conduct	3
	Unethical conduct	4
	Dissatisfaction with services rendered	12

REGULATIONS

The Council—exercising the regulatory powers granted under the Bylaws—prepared and first distributed in 1956 a set of "Regulations for the Processing of Grievances and Complaints against Members of The Medical Society of New Jersey and its Component Societies." At the beginning of each administrative year, copies of these regulations are supplied to chairmen of judicial committees and to secretaries of component societies. As the result of its experience these past years, the Council is now revising the regulations and will issue them to chairmen of county judicial committees early in the next administrative year.

WAIVER FORM

The 1960 House of Delegates adopted a resolution directing the Board of Trustees to explore the possibility of securing legislation granting the privilege of immunity to all procedures of the Judicial Council and the judicial committees of the various component societies. Society's Legal Counsel subsequently pointed out that to "sponsor and introduce legislation soliciting confidentiality for these records would be futile, in view of the position taken consistently by the Legislature refusing privileged communication to physicians." As an alternative, the Council then considered the utilization of a waiver in conjunction with the acceptance of complaints. Under the terms of the contemplated waiver the complainant, in consideration of the privilege granted to have the complaint dealt with in confidence through the judicial mechanism, would agree not to subpoena any records compiled in conjunction with the processing of the complaint.

The Council, with the assistance of Society's Legal Counsel, in a series of meetings evolved a waiver form. However, at the October meeting (1962) the Council came to the conclusion that the introduction and use of this legalistic form might jeopardize the informal and nonlegalistic character of the judicial mechanism and militate against the declared intent of the

judicial mechanism: "To improve public and intra-society relationships by making available a means whereby differences and disagreements can be brought informally to a settlement that is fair to the interests of all parties." The Council therefore decided to table the matter.

OPINION

ETHICAL ACCEPTABILITY OF PHYSICIANS' CHARGING, OR RETAINING FEES FOR, MEDICAL SERVICES RENDERED THE DEPENDENTS OF OTHER PHYSICIANS

The Council agreed that his was not so much a question of ethical conduct as one of professional courtesy. It was the Council's opinion that the average physician does not knowingly charge a colleague, or anyone directly dependent upon a colleague for support, for professional services rendered. However, if he does charge, there is no violation of an ethical principle.

It was the opinion of the Council that there are many physicians who do not wish to take advantage of this professional courtesy. Too, the introduction of health insurance and its coverage of many physicians and their families—which makes funds available for medical and surgical services—has lessened the feasibility of physicians' rendering gratuitous service to their colleagues' dependents.

The Council unanimously concluded that this decision must be met by each individual physician offering the service. If he offers to render to colleagues and their dependents his professional services gratuitously, he is indulging a professional courtesy; if he chooses not to observe this courtesy, he is not being unethical.

Approved (page 337)

EXECUTIVE DIRECTOR

Richard I. Nevin, Trenton

(Reference Committee "A")

Successive annual reports of any one organization, like the successive children of the same parents, inevitably manifest a repetitiveness of pattern and characteristics. This is merely to indicate that it is difficult to say in an annual report what has not been said before.

The year has been one of sustained activities at practically all levels of operations; it has also been one of distinguished cooperation. Board, council, and committee meetings have consistently dealt with extended agendas, and, in consequence, meetings have been of uniformly longer duration than in preceding years. But, as the President reflects in his Report, through the good work of our officers and committee members, we have kept abreast of the exactions of the Society's purposes and interests, and we have sustained and deepened our contact and collaboration with outside groups in the professional fields, in the areas of state legislative and administrative actvities, and in the sphere of community services.

Thanks to the refusal by Congress to capitulate to the pressures to adopt hastily contrived legislation to effect the inclusion under social security of hospital care for the elderly, we were not called upon this year for the sustained and vigorous activity which, in this connection, we indulged in the preceding year. But, as if in counterbalance, state legislation involving medical interests increased in volume and necessitated more time and study on the part of all who deal with this most important phase of the Society's activity. At its first meeting this year, following the early 1963 sessions of the Legislature, the Council on Legislation was called upon to consider bills in number approximately equal to the total for the year of 1962.

It is gratifying to report that this year has witnessed the enactment of legislation which MSNJ has strongly urged to effect the implementation of the Kerr-Mills law in New Jersey. Regulations are now being made and administrative details are being worked out to enable the program to meet its scheduled starting deadline of July 1, 1963.

Likewise this year saw the adoption of legislation to permit the incorporation of self-employed professional persons—a measure which The Medical Society of New Jersey urged and supported. A bill to protect from

liability those who voluntarily render emergency care to victims of accidents on our highways—the so-called "Good Samaritan" bill—is, at this writing, before the Governor for his signature. This is legislation which our Society helped to devise and which it strongly supported.

Two other pieces of Society-sponsored legislation may be mentioned at this time as in good position for passage: legislation to regulate blood bank operations, and a bill to permit an individual to will his eyes to science for humanitarian purposes. We shall continue our efforts to bring both these measures to enactment into law.

It is not for me in this report to recapitulate the work of the more than two-score committees whose activities are being accounted for before the House. However, I can and do assure the members of the House, and all the members of our Society, that to these committees and their members we owe a profound debt of gratitude for faithful, devoted, and generous services that have supported and advanced our ideals and purposes as an organization.

My duty has been to be part of all that The Medical Society of New Jersey has been thinking, doing, and saying. To this end, I have participated in meetings, conferences, conventions, and hearings, to the number of 175. I have appeared before 13 component societies and auxiliaries, have made five out-of-state trips on Society business, and have presented talks before 24 audiences.

Through the kindness of the board, at the March meeting of that body, I was assigned a new title as "Executive Director." I was essentially no less happy as "Executive Officer" than I expect to be as "Executive Director." I am deeply grateful to the board for the confidence it has thus shown in me. It shall be my earnest goal to continue to give to the Society my best and my utmost in order well to serve our aims and interests. I shall assiduously strive to continue to give satisfaction as a "good and faithful servant" both of The Medical Society of New Jersey, and of the principles of charity, truth, and justice for which it stands.

In times such as these, it is especially gratifying to serve a worthy cause with men and women of noble dedication and unselfish effort. Such are our officers, our council and committee members, and the members of our staff. To all of them, from my heart I offer thanks for the inspiration and deep satisfaction of working with them to build a better Medical Society of New Jersey and, by means of its contribution and the contribution of all its members, to build a better world.

Approved (page 337)

You Must File a Personal Property Tax Return!

The furniture and equipment used in your office practice are construed as "business personal property." Under a new law, these must be reported subject to penalty. However, no tax will be imposed this year on the basis of this informational return. If you have not received a report form, apply for one at once. Failure to receive a form is not accepted as justification for failure to report.

The following is an official release on this subject from the State Department of the Treasury:

> Chapter 9, Laws of 1963—which postpones the effective date of Chapter 51, Laws of 1960—also requires all owners of business personal property in the State of New Jersey to file an informational tax return. All professional people, including doctors, are required to file this form by August 1, 1963.
>
> The personal property informational returns are to be filed with the State Local Property Tax Bureau for purposes of statistical analysis only. The informational return is thus an invitation to all owners of business personal property to lay out the facts necessary to answer the many unanswered questions which have plagued taxpayers and tax administrators since Chapter 51 was first adopted in 1960.
>
> If the results show that Chapter 51 would cause business personal property to absorb too much of the local property tax bill, then the Legislature will be in a position to make some changes.
>
> Professional men are cautioned that failure to receive the informational return form in the mail does not relieve them of the responsibility of filing by August 1, 1963.
>
> Blank forms may be obtained at the office of your local assessor, at your County Board office, or by writing to the Local Property Tax Bureau, Statistical Section, P.O. Box 1998, Trenton 25.

ANNUAL MEETING

Edward E. Seidmon, M.D., Chairman, Plainfield

(Reference Committee "H")

The program for the 1963 annual meeting was arranged with exceptional care and screening. Continued excellent cooperation was noted between the section officers and the chairmen of the Committees on Scientific Exhibit and Scientific Program. The intention of all was to allow for a wide variety of program selection to increase the interest of all segments of the medical profession. The program has been especially beamed toward the general practitioner, and the papers and exhibits are correlated and integrated.

The educational, scientific, and technical exhibits will total 102. The scientific exhibits are a culmination of the results of the latest medical investigations available in the past year. It was not possible to accept all applications for space in the technical exhibits this year, as the requests for space were greater than that available. Members are urged to visit the exhibits and take advantage of the latest information which they present. The exhibits are an important educational addendum to the scientific sessions.

Again this year, through the cooperation of Smith Kline & French Laboratories, an excellent motion picture program covering numerous scientific interests has been arranged. The committee wishes to express its appreciation to Smith Kline & French Laboratories for this valuable addition to the annual meeting.

By action of the Board of Trustees, Monday, May 13, will be an open day for the House of Delegates. This has made possible the scheduling of a two and one-half day scientific program.

In cooperation with the New Jersey Academy of Medicine and the New Jersey State Department of Health, a special program will be presented on Tuesday, May 14.

For the advance information of the membership, the annual meeting program was published by the committee and mailed in early February. Copies of the advance program were also mailed to New Jersey, New York City, and Philadelphia hospitals, with a special invitation to their medical staffs to attend the scientific portions of the annual meeting. The editors of bulletins of the New York, Pennsylvania, Connecticut, Maryland, and Delaware state societies were requested to publicize the annual meeting and extend an invitation to their members to attend, indicating that there is no registration fee for out-of-state physician-guests.

Attendance during the 1962 annual meeting was 2,291, of which 1,208 were physicians; all component societies were represented.

The increasingly heavy convention schedule in Atlantic City each spring has made it advisable to set annual meeting dates at least four years in advance in order to assure desirable dates and hotel accommodations. The House of Delegates has already approved the following annual meeting dates which have been confirmed with Haddon Hall:

198th annual meeting — Saturday-Wednesday, May 16-20, 1964

199th annual meeting — Saturday-Wednesday, May 15-19, 1965

200th annual meeting — Saturday-Wednesday, May 14-18, 1966

RECOMMENDATION

That the 201st annual meeting be held at Haddon Hall, Atlantic City, Saturday-Wednesday, May 13-17, 1967.

Approved (page 349)

*SCIENTIFIC EXHIBITS

Milton Ackerman, M.D., Chairman, Atlantic City

(Reference Committee "H")

The committee took the following actions during the year, 1962-63:

1. Noted with gratitude the assignment of the Vernon Room for the Scientific Exhibit and of the Solarium for the motion picture theater as per the request of the committee.

2. Reviewed the applications for the Scientific Exhibit and assigned space to the acceptable applicants. Several matters pertinent to the designation of exhibits sponsored by institutions and those which were considered primarily educational were resolved. It was decided, in instances where exhibits were sponsored by institutions, that the name of the individual physician sponsored be noted on the exhibit signs to be accompanied by the address of the institution. In case of exhibits which were considered to be educational-scientific, it was decided that these types of exhibits would not be eligible for consideration in the award classifications.

3. Selected a group of suitable motion picture films and established a schedule for the showing of these films in the motion picture theater. It was decided that, in addition to the large placard listing of the entire film program which is posted in several locations, there world be a small placard at the theater entrance, indicating the film "now showing."

4. At the request of the Committee on Annual Meeting, the committee revised the time schedule for the exhibits; the Scientific and Educational Exhibits, and motion picture theater to be opened at 1:00 p.m. on Sunday, May 12, and the Industrial Exhibits to open at 1:00 p.m. on Monday, May 13.

5. Organized an Awards Committee for the judging of exhibits.

Approved (page 349)

*SCIENTIFIC PROGRAM

Herschel S. Murphy, M.D., Chairman, Roselle

(Reference Committee "H")

A joint committee of the Committee on Annual Meeting, the Subcommittee on Scientific Programs and the section officers was held on Sunday, June 10, 1962. Plans were set up for the various section meetings and various joint section meetings.

In October a second meeting was held, at which time the scientific program, with the names of the speakers and their subjects, was discussed more fully. With the joint programs agreed upon, we find that we will have ten scientific sessions in all. There will also be a special scientific panel session, presented jointly by the Academy of Medicine of New Jersey and the New Jersey State Department of Health, on "Strokes, Their Diagnosis and Treatment."

We feel that the scientific sessions will offer to our entire membership programs which will appeal to their special interests.

We wish to congratulate the section officers on their selection of topics and speakers. All members of our Society are urged to attend the scientific sessions which will be of most interest to them.

Approved (page 349)

*Subcommittees of the Annual Meeting Committee

CREDENTIALS

Marcus H. Greifinger, M.D., Chairman, Newark

(Reference Committee "A")

The Committee on Credentials throughout the year reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies.

The following statistical breakdown reflects the committee's activities during the period June 1, 1962 to April 1, 1963:

	Associate	Advancement to Active	Active	Total
Received	239	166	52	457
Reviewed and Found:				
Satisfactory	213	154	46	413
Unsatisfactory	1*	0	0	1
Pending	25**	12	6	43

*Did not hold a degree in medicine.

**Includes two applicants holding M.D. degrees acquired by conversion of D.O. degrees through the program of the California College of Medicine, which terminated September 30, 1962.

MEMBERSHIP APPLICATION

The committee revised the official membership application, and ordered that the new forms be printed. The new application forms will be distributed early in the next administrative year.

The format of the application has been changed to make it easier to complete and more explicit as to the exact information required of applicants. The only major changes in content were:

1. The component society's certification that the credentials have been reviewed by the appropriate committee of the society of application has been moved from Form #3 (Record of The ..... County Medical Society) to the application form itself.
2. The AMA biographical information form requested by the secretary of the society of application is to be attached to MSNJ's copy of the application.

The committee desires to express appreciation to the officers of component societies for their cooperation.

Approved (page 337)

FINANCE AND BUDGET

Carl N. Ware, M.D., Chairman, Ocean City

(Reference Committee "B")

A review of the expenses of the first ten months of the current administrative year, and an estimation of the expenses for the final two months, indicate that the individual budget accounts are sound.

THE JOURNAL

The anticipated deficit for publication of THE JOURNAL, Editorial Office expenses and travel will be charged off to the unexpended balance in the budget accounts at the end of the fiscal year. This will result in a net deficit in the 1962-63 total budget allotted.

In view of a 65 per cent increase in advertising rates and an increase in the subscription rate—effective June 1, 1963—the Publication Committee next year expects to realize sufficient additional income to operate in the black.

A complete financial statement of the current year's operation of THE JOURNAL is included in the report of the Publication Commi tee.

MEDICAL STUDENT LOAN FUND

The 1961 House of Delegates authorized the transfer of $60,000 to the Medical Student Loan Fund—on loan and without in-

terest—to enable the Fund Committee to carry on its program. $53,500 has been paid out in loans these past two years. The balance of $6,500, plus approximately $21,000 in the Fund's general account, will, it is estimated, cover loans in the coming year.

The official auditors of the Society's books recommended that the $60,000 transferred to MSLF should be a grant or appropriation—not a loan—since both funds are under the control of the Board of Trustees. The auditors pointed out that carrying the transfer as a loan sets it up as an asset under the general fund which inflates the general fund and does not truly represent liquid funds.

The Audit Review Committee, appointed by the Board of Trustees, recommended that the transfer of monies to MSLF be made by annual action, if need is indicated, and that such transfers be not on a loan basis but be definite contributions.

The Board directed the above recommendation to the attention of the Finance and Budget Committee for consideration in its preparation of the budget for 1963-64, and further directed that the committee request the House of Delegates to convert the 1961 loan of $60,000 into a grant. As the auditors pointed out, should a surplus ever exist in the MSLF, the amount of this or any future grant can be transferred back to the general fund by action of the Board of Trustees.

AMERICAN MEDICAL ASSOCIATION—EDUCATIONAL RESEARCH FOUNDATION

From 1959 to 1961, the House of Delegates set the per capita level of contribution to AMA-ERF in addition to, and not as part of, the budgetary assessment, with both being paid at the same time. In 1962, the House did not take any action with regard to a contribution to AMA-ERF in 1963.

The 1959-61 method of contribution maintains the budget on an equalized basis. Your committee definitely feels that this method of contribution should be continued if a contribution to AMA-ERF for 1964 is voted by the current House of Delegates.

1964 ASSESSMENT

The computation of cash surplus at the close of the current fiscal year is estimated at $119,359.76—19 percent above the $100,000 sum which has been indicated as the desired surplus amount at the beginning of each new fiscal year.

The actual requirement for the proposed 1963-64 budget is $40.51 per capita. By using a few thousand dollars from surplus, the 1964 assessment can be retained at $40.00 per capita.

1963-64 BUDGET

The proposed budget for 1963-64, in the total amount of $242,091, contains items totaling $3,557.63 which are subject to specific action by the Board of Trustees. However, the committee deemed it advisable to project the maximum proposed budget in this report rather than to omit the items and make increased adjustments in the figures in a supplemental report. It is the opinion of the committee that the budget should provide the necessary funds for the efficient operation of the Society's business during the year, but it is not required that the money be spent.

As requested by the House of Delegates, the committee is listing explanatory footnotes on items showing a marked difference between current and proposed budgets.

RECOMMENDATIONS

1. That the House of Delegates convert into a grant the 1961 loan of $60,000 to the Medical Student Loan Fund.

Adopted (page 337)

2. That the budget for 1963-64 be adopted in the total sum of $242,091.

Adopted (page 337)

3. That the 1964 assessment be adopted at $40.00 per capita, with no provision for a contribution to AMA-ERF.

Adopted (page 337)

4. That if the House of Delegates votes a contribution to AMA-ERF for 1964, the per capita level of contribution be set by the House in addition to, and not as part of, the budgetary assessment, and that both be paid at the same time.

Adopted at $5 per capita (page 337)

Account	Proposed 1963-64 Budget	Foot-note	Current 1962-63 Budget
A- 1—Executive Salaries	$ 58,204.93	*	$ 52,590.31
A- 2—Executive Office Salaries	55,128.09	*	53,553.69
A- 3—Executive Office Expenses	2,100.00	*	1,950.00
A- 4—Executive Travel	2,425.00		2,625.00
A- 5—House Maintenance	17,205.00	*	16,547.00
A- 6—Treasurer	3,855.00		3,730.00
A- 7—Finance and Budget Committee	100.00		100.00
A- 8—Secretary	1,350.00	*	650.00
A- 9—Salary Taxes	3,795.00	*	3,286.00
A-10—Insurance	4,488.00		4,534.00
A-11—House Reserve	11,370.00	*	5,000.00
C- 2—Legislative Council	6,200.00	*	7,500.00
C- 3—Public Health Council	2,900.00	*	2,300.00
C- 4—Public Relations Council	9,100.00		9,250.00
C- 5—Medical Services Council	1,400.00		1,300.00
D- 1—President and Presidential Officers	11,140.00		11,240.00
D- 2—AMA Delegates	11,755.00	*	8,030.00
D- 3—Woman's Auxiliary	3,350.00	*	3,975.00
D- 4—Medical Education Committee	325.00		325.00
D- 5—Conference Groups	500.00		500.00
D- 6—Credentials, Membership, Directory and Physicians Placement Service	3,150.00	*	5,662.00
D- 7—Disaster Medical Care Committee	200.00	*	100.00
D- 9—Archives and History	100.00		100.00
D-10—Blood Bank Commission	400.00	*	250.00
D-11—Medical Defense and Insurance Com.	350.00		450.00
E- 1—Board of Trustees	6,000.00		6,000.00
E- 2—Contingent	10,000.00		10,000.00
E- 3—Judicial Council	900.00		900.00
E- 4—Legal	8,300.00	*	6,300.00
E- 6—Medical Student Loan Fund	5,000.00		5,000.00
TOTAL	$242,091.00		$223,748.00

FOOTNOTES (*)

A- 1—Increase due to salary increases to executive personnel authorized by the Board of Trustees.

A- 2—Increase due to annual increments and pension premium for one staff member now eligible to participate.

A- 5—Increase due to property tax rise and rate increase for insurance.

A- 8—Increase due to cost of publication of annual reports (transferred to the Office of the Secretary from THE JOURNAL office) which were previously published without cost as preprints from the Transactions issue of THE JOURNAL.

A- 9—Increase due to rise in salary tax rate.

A-11—Increase due to projected capital expenses and periodic large maintenance costs, and equipment replacement.

C- 2—Decrease due to reductions in view of 1962-63 expenditures.

C- 3—Increase due to increased activity of council and its eight special committees.

D- 2—Increase due to allotment directed by action of the Board of Trustees "for a suitable hospitality suite to be open to all official visitors, with a limit of $5,000 authorized" for the 1963 AMA annual meeting in Atlantic City.

D- 3—Decrease due to reduction in cost for expenses of Auxiliary Officers and Delegates to the 1963 national meeting in Atlantic City.

D- 6—Decrease due to postponement of publication of Membership Directory and cost distributed over at least three years, rather than usual two years; and discontinuance of Physician Placement Service.

D- 7—Increase due to expansion of committee's activities.

D-10—Increase due to expansion of commission's activities.

E- 4—Increase due to inclusion of increased retainer for legal counsel which is subject to Board determination.

HONORARY MEMBERSHIP

F. Clyde Bowers, M.D., Chairman, Mendham

(Reference Committee "H")

No nominations were submitted to the Committee on Honorary Membership. Consequently, no meetings of this committee were held during this administrative year.

No Action (page 349)

MEDICAL DEFENSE AND INSURANCE

Daniel F. Featherston, M.D., Chairman, Asbury Park

(Reference Committee "D")

MAJOR MEDICAL EXPENSE INSURANCE

The Essex, Bergen, and Monmouth County Medical Societies conducted active enrollments for the major medical policy and more than 50 per cent of their members applied so that the company was able to issue policies to the impaired risks who applied during the enrollment. Major medical enrollments are now underway in the Passaic and Hudson County Medical Societies. As of February 15th, 1963, 1753 of our members had already received major medical policies issued through the National Casualty Company. Under the major medical program, 26 claims were paid with the highest amount thus far being $1,431.40.

ACCIDENT AND HEALTH INSURANCE

During the past year the E. & W. Blanksteen organization successfully completed enrollment for the Nationwide Mutual Insurance Company's additional plan of accident and health insurance in Essex, Bergen, Passaic, Hudson, Monmouth, Middlesex, Camden and Union County Medical Societies, with the result that impaired risk applicants in those counties were included in the insurance program.

As of February 15, 3819 of our members were insured under the National Casualty Company accident and health program and 2399 of our members were insured under the Nationwide Mutual Insurance Company accident and health insurance program.

Under the National Casualty Company accident and health program, disability claims were paid to 487 of our members with highest claim paid to any one individual being $6,740. In the Nationwide Mutual Insurance Company there were 164 disability claims paid; the highest amount paid to any one individual was $2,800.

LIFE INSURANCE

Our five year renewable and convertible term life policy, available through the Blanksteen organization, showed an increase of participation during the past year as the result of the state society sponsored November "Life Month." As of February 15, 1963, 1831 of our members were insured under the life program for a total of in excess of twenty-three million dollars of life insurance. Since the report of a year ago, there were 17 death claims paid for a total of $170,000. Of these deaths, 14 were impaired risks when insured and were included in the insurance program by virtue of our having received the required quota at the time of the original enrollment. Since the inauguration of this life program in March, 1959, there have been a total of 49 paid death claims out of which 39 were impaired risks at the time policies were issued to them.

HIGH LIMIT ACCIDENT POLICY

During the past year we inaugurated a new insurance program, through E. & W. Blanksteen, the Six-Point, High Limit Accident Policy of the Nationwide Mutual Insurance

Company, commonly known as an accidental death and dismemberment policy.

This policy provides accidental death, dismemberment and permanent and total disability benefits as a result of accidents in amounts from $25,000 to $200,000 for the member and $25,000 up to $100,000 for the spouse. In a six-week enrollment period recently held, approximately 30 of our members applied for this policy, which is issued on a non-selective basis requiring only that the member be in active practice.

PROFESSIONAL LIABILITY INSURANCE

Under the Society's approved program through the American Mutual Liability Insurance Company, 18 claims were disposed of during this year at a total cost of $70,330 with no distinct pattern as to the type of negligence involved or the specialty of the doctor.

The chairman wishes to thank the committee members for their attendance at our meetings and complete cooperation at all times—Doctors Mettler, Hillman, Slobodien, Lance, and Palazzo—and to thank the Administrative Secretary for her assistance.

RECOMMENDATIONS

1. That the E. & W. Blanksteen Agency be continued as the official brokers for our Major Medical Expense Insurance, Accident & Health, Life Insurance, and High-Limit Accident Insurance programs.

2. That the American Mutual Liability Insurance Company be continued as the official designated carrier for our Professional Liability Insurance program.

Approved. Recommended that efforts be made on a statewide basis to increase the enrollment of the members of MSNJ in the program offered by the American Mutual Liability Insurance Company to provide the company with the most reliable statistics and figures from which they will be able to establish in a final form our rates of payment for this liability coverage. (page 341)

PARTICIPATION THROUGH MARCH 1, 1963

County	Eligible	Insured	Percentage
Atlantic	165	16	10
Bergen	702	423	60
Burlington	128	24	20
Camden	371	24	6
Cape May	36	8	22
Cumberland	100	43	43
Essex	1,557	1,022	66
Gloucester	76	11	14
Hudson	625	250	40
Hunterdon	55	44	80
Mercer	423	131	31
Middlesex	336	218	65
Monmouth	339	236	70
Morris	286	173	60
Ocean	85	31	36
Passaic	588	384	65
Salem	48	4	8
Somerset	100	78	78
Sussex	33	32	97
Union	597	372	62
Warren	37	21	57
Total	6,687	3,545	53

CLAIMS

	For Policy Year Expiring:			
	11-1-60	11-1-61	11-1-62	11-1-63
Anesthesiologist	.	9	32	9
Dermatologist	.	2	8	. .
General Practice	3	9	34	7
General Surgery	1	13	34	2
Internist	. .	7	19	5
Neurology	2	2	2	. .
Ob-Gyn	1	10	23	2
Ophthalmology	. .	1	. .	. .
Orthopedics	2	5	18	2
Pathology	. .	1	. .	
Pediatrics	. .	6	12	3
Plastic Surgery	. .	2	1	
Proctology	. .	2		
Psychiatry	. .	.	2	
Radiology	. .	1	5	3
Urology	.	3	5	
E.E.N.T.	.	2	6	
Neuropsychiatry	.		1	
Premises	. .		7	2
Total	9	75	209	35

MEDICAL EDUCATION

Sherman Garrison, M.D., Chairman, Bridgeton

(Reference Committee "D")

This year, in consequence of the action of the 1962 House of Delegates, the committee has added to the scope of its responsibilities concern for "the intern and resident training program in the State." In this connection the committee is developing a questionnaire to be submitted to New Jersey hospital administrators, chiefs of staff, and directors of medical education or chairmen of medical intern programs; and a second questionnaire to be submitted to interns and residents in hospitals of New Jersey for the purpose of arriving at a full appreciation of the present situation and to make possible recommendations concerning it.

In common with many members and groups of members of The Medical Society of New Jersey, the committee is concerned about the effects on New Jersey hospitals of the action of the AMA House of Delegates, meeting in Los Angeles in November 1962, when, in adopting the recommendation of the Council on Medical Education and Hospitals, it approved "at least 25 per cent of the total house staff (interns and residents) of a hospital should be graduates of accredited United States or Canadian medical schools. When United States and Canadian graduates represent a lesser portion of the house staff for two successive years, this will warrant that serious consideration be given to disapproving the intern program." In support of its attitude, the committee has forwarded to the Board of Trustees a resolution urging that this Society take whatever steps are necessary to induce the AMA House of Delegates to reconsider this decision and to properly amend it.

Adopted (page 341)

MEDICAL STUDENT LOAN FUND

Luke A. Mulligan, M.D., Chairman, Leonia

(Reference Committee "B")

In its six years of operation, the Medical Student Loan Fund has granted a total of $82,475.35 in 87 loans to 64 New Jersey medical students. Five loans are being repaid by four recipients. To April 1, 1963, $1,400 has been repaid on principals, and $220.13 in interest.

As of April 1, 1963, the gross fund totals $97,993.41—$90,781.41, General Fund; $5,792, Albert Barker Kump Memorial Grant; $1,430, Joseph E. Mott Memorial Grant. Approximately $27,000 will be available for loans in 1963-64.

The committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of contributors to date (April 1, 1963) since the last report follows:

Albert Barker Kump Memorial Grant

Dr. Frank J. T. Aitken; Cumberland County Woman's Auxiliary.

In memory of:

Mrs. Louis J. Kauffman.

General Fund

Board of Trustees, Fellows; County Societies: Hudson, Mercer, Salem, and Somerset.

State Auxiliary Executive Board, Fellowettes; County Auxiliaries: Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Somerset, Union, and Warren.

Dr. and Mrs. Walter S. Booth, Mrs. Ralph K. Bush, Dr. and Mrs. E. Childers, Mrs. Helen Con-

nolly, Mrs. Millard Cryder, Mr. and Mrs. S. Diamond, Dr. and Mrs. W. E. Dodd, Dr. and Mrs. Solomon S. Ellenson, Dr. and Mrs. Floyd D. Gindhart, Dr. and Mrs. Rubin Grossman, Dr. and Mrs. Harold F. Hughes, Dr. and Mrs. E. Jasionowski, Dr. and Mrs. A. Lepis, Dr. and Mrs. Samuel J. Lloyd, Dr. and Mrs. Benjamin Macchia, Mrs. Edward Mancene, Mrs. Thomas P. McConaghy, Dr. and Mrs. Carl J. Records, Mrs. William Roe, Dr. and Mrs. Joseph Rube, Mrs. I. Saurman, Dr. and Mrs. John J. Torppey, Dr. and Mrs. James C. Tsucalas, Mrs. John S. Van Mater, Mrs. H. Roy VanNess, Dr. and Mrs. Carl N. Ware, and Dr. and Mrs. Joseph Ziegler.

In memory of:

Mrs. Anna M. Anderson, Mrs. Josephine Baron, Edgar Becker, Dr. Francis X. Brophy, Dr. Robert Buermann, Mrs. Hazel Butler, Dr. John Caggiano, Dr. Byron Close, Mrs. Crankshaw, John F. Crosby, Dr. W. E. Duryea, Dr. Lancelot Ely, Dr. Charles Fadem, Dr. Abraham Goldstein, Dr. I. Graber, Dr. Francis Haggerty, Mrs. Ada Hepner, Mrs. Hillman, Mrs. Gertrude Hollingsead, Mrs. Rhoda Jaques, Dr. August Jonas, Dr. Martin A. Joyce, Dr. Julius Kahn, Dr. Carl J. Kapp, Dr. Leonard Kimmel, Dr. Samuel A. Lear, Maurice Levin, Harry Levy, Mrs. Lloyd, Dr. C. Percy Lummis, Judge Alex MacLeod, Edward J. McCardell, Dr. Thomas P. McConaghy, Anne McCormack, Mrs. R. J. McDonald, Patrick J. McNulty, Katherine Mores, Dr. Guy Moulton, Dr. Leo J. Murphy, Lynn Nagan, Mrs. Naylor, Gabriel O'Bester, Dr. Harry J. Perlberg, Sr., Dr. William Pindar, Dr. Ethyl M. Powis, Joseph Roth, Dr. August Schlein, Mary Sexton, Dr. Lee Solworth, Max Spillar, Mr. Steelman, Dr. Margaret Sullivan, Mrs. W. Scott Taylor, Commissioner John J. Tramburg, Dr. Hugh Tyndall, Mrs. Helen L. Van Mater, Anne Walker, and Dr. Humphrey D. Wolfe.

In honor of:

Mrs. Walter S. Booth, Mrs. A. Guy Campo, Mrs. Arthur J. Casselman, Mrs. Wilbur L. Davison, Mrs. Floyd D. Gindhart, Mrs. Harry V. Hubbard, Mrs. Donald K. Sass, Dr. Anthony L. Spirito, Dr. Anthony M. Spirito, Mrs. John J. Torppey, and Mrs. H. Roy VanNess.

DISTRIBUTION OF LOANS

County of Residence	Medical School	Students	Loans Granted 1957-1962	Loans Granted 1962-1963
Atlantic	Hahnemann	1	$ 1,000.00	$
	Pittsburgh	1		1,000.00
	Tufts	1		1,000.00
Bergen	Hahnemann	1	1,000.00	1,000.00
	Seton Hall	3	2,000.00	1,000.00
	Woman's Medical	1	1,000.00	
Burlington	Duke	1	1,000.00	1,000.00
	Jefferson	1	2,000.00	
Camden	Jefferson	1	2,000.00	
	Michigan	1	1,000.00	1,000.00
	Seton Hall	2	1,000.00	700.00
	Temple	1	500.00	
Cumberland	Jefferson	1	2,000.00	
Essex	Bern	1	2,325.35*	
	N. Y. Medical	1	1,000.00	
	Seton Hall	4	4,000.00	2,000.00
	St. Louis	1	500.00	
	Temple	1	1,000.00	
Gloucester	Temple	1	2,000.00	
Hudson	Harvard	1	1,000.00	
	Howard	1	400.00	
	Seton Hall	9	10,000.00	800.00
	St. Louis	1	1,000.00	1,000.00
Mercer	Hahnemann	2	3,000.00	
	Howard	1	1,000.00	
	Meharry	1	250.00	
	Mississippi	1		1,000.00

	Seton Hall	3	3,000.00	2,000.00
	St. Louis	1	700.00	
Middlesex	N. Y. Medical	1	2,000.00	
Monmouth	Seton Hall	1	2,500.00	1,000.00
	Temple	1		1,000.00
	Up-State N. Y.	1		1,000.00
Morris	Dartmouth	1		1,000.00
	Seton Hall	1		1,000.00
Passaic	N. Y. Medical	1	1,000.00	
Somerset	Temple	1	2,000.00	1,000.00
	Western Reserve	1	1,000.00	
Union	Seton Hall	9	4,800.00	4,000.00
15 Counties	18 Medical Schools	64	$58,975.35*	$23,500.00
			($82,475.35*)	

(*Includes payment of insurance premium)

Approved (page 337)

NOMINATIONS FOR EMERITUS MEMBERSHIP

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1963 annual meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6, of the Constitution, all nominees are now and have been members in good standing of a component society for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

ATLANTIC COUNTY

V. Earl Johnson, Fort Pierce, Fla. (formerly Margate); age 66

BERGEN COUNTY

John H. Irwin, Demarest; age 65
Arthur W. Pindar, Bridgeport, W. Va. (formerly Teaneck); age 63
Dorothea Vann, Englewood; age 50
Gladys C. Winter, Tenafly; age 58

BURLINGTON COUNTY

Thomas J. Summey, Charlottesville, Va. (formerly Mount Holly); age 76

ESSEX COUNTY

Leon J. Camche, Newark; age 71
Thomas W. Harvey, East Orange; age 79
Edmund E. Lewandowski, Pompano Beach, Fla. (formerly Irvington); age 60
Dean W. Marquis, Riviera Beach, Fla. (formerly East Orange); age 63
Lewis Robbin, Hohokus; age 71
Merton H. Stevens, Eastham, Mass. (formerly East Orange); age 68
Earl LeRoy Wood; Newark; age 69

MIDDLESEX COUNTY

Frederick J. Koelsch, New Brunswick; age 68

PASSAIC COUNTY

Harold W. Laauwe, Wayne; age 60
Elizabeth Nesbitt, Little Falls; age 77

UNION COUNTY

Cyril M. Canright, Cranford; age 69
Charles F. Card, Seaside Park; age 74
Robert J. Childers, Plainfield; age 76
Jerome J. Reich, Hillside; age 65

Approved (page 349)

SUPPLEMENTAL REPORT

The following additional nomination for election to Emeritus Membership at the 1963 annual meeting was received from the *Essex County Medical Society*:

Arthur G. Pilch, Miami, Fla. (formerly Bloomfield); age 71

Approved (page 349)

PUBLICATION

Frank L. Rosen, M.D., Chairman, Maplewood

(Reference Committee "B")

THE JOURNAL's financial health during the past year has again been poor. The continued combination of decreasing advertising appropriations and increasing operating costs has resulted in a deficit for the third consecutive year. The Publication Committee has held three regular meetings and has worked closely with the Board of Trustees in an attempt to return THE JOURNAL once again to operation within its advertising income.

JOURNAL CONTENT

A tabular comparison of the last four years will be of interest. In the face of decline of other departments, the conspicuous expansion of the "State Activities" is shown in this table. Sixty-three original articles were published, fifty-seven of which were by New Jersey physicians. The few papers by out-of-state authors represented material delivered at meetings in New Jersey. The "State Activities" line includes obituaries, civil defense material, and miscellaneous items. Numerals indicate number of pages.

The four-year decline in advertising is dramatically shown in the table. Nearly all medical journals suffered similarly. The drop from 1,162 pages to 781 pages is a 32 per cent loss.

	1959	1960	1961	1962
Book Reviews	23	25	33	28
Original Articles	389	324	255	238
Editorials	29	30	34	36
Historical Material	13	11	6	0
State Activities	242	280	240	263
Letters & Announcements	21	15	19	28
County Society Reports	31	33	25	25
Psychosomatic Profiles	0	0	0	4
Total of text material	748	718	612	622
Advertising	1162	1124	844	781
Grand total of pages	1910	1842	1456	1403
Ratio: advertising/text	61%	62%	56%	55.6%

COUNTY REPORTS

In a further effort to economize, the Board of Trustees approved the discontinuance—effective January 1, 1963—of "County Society Reports" in THE JOURNAL, because of their duplication at county level. This feature was inaugurated at a time when counties did not have bulletins. Now most of the counties take care of this matter themselves.

STATEMENT OF INCOME AND EXPENSE

As directed by the 1962 House, the Publication Committee presents this complete financial statement, as part of its annual report. It covers the interval from June 1, 1962 through March 27, 1963.

Income:		
Advertising—SMJAB	$ 26,744.77	
Advertising—Local	8,324.57	
Subscriptions, Extra copies	443.83	
SMJAB rebates	722.49	
Total income		$ 36,235.66
**Expenses*:		
Journal publication	$ 43,657.55	
Office expense	522.14	
Travel	332.69	
Committee expenses & travel	59.55	
Discounts & commissions, SMJAB	4,257.59	
Discounts & commissions, local	2,808.19	
Bad debts	387.60	
Total expenses		$ 52,025.31
Excess of expenses over income		$ 15,789.65
JOURNAL accounts receivable March 27, 1963		$ 5,803.56

*All expenditures are exclusive of salaries charged to appropriations provided in the general budget for each administrative year.

Note: Net deficit May 31, 1961 of $1,196.72 was charged to the unexpended budget appropriations for the fiscal year ended May 31, 1961.

Net deficit May 31, 1962 of $16,040.82 was charged to surplus.

ADVERTISING

Effective June 1, 1963, advertising rates in THE JOURNAL will be increased 65 per cent "across the board," to bring our rates in line with those of journals of comparable size and quality throughout the country. Classified advertising rates will also be increased. Discontinued will be the Prescription Pharmacists' and Representative Funeral Directors' listings, as such. Discounts will no longer be given.

SUBSCRIPTIONS

Effective June 1, 1963, subscriptions to THE JOURNAL will be at a rate of $5 per year, or 50 cents per issue—payable in advance. Back copies of issues more than two years will be sold, when available, at $1 each, plus postage.

Members of MSNJ will continue to receive THE JOURNAL as a benefit of membership.

CIGARETTE ADVERTISING

Because of the objection from members, the committee discussed the desirability of continuing cigarette advertising in THE JOURNAL. It is noted that the AMA discontinued it in 1954. The Board of Trustees has approved the action of the committee in discontinuing cigarette advertising in THE JOURNAL, effective June 1, 1963. This decision does not exclude advertisements for cigars and pipe tobacco.

NEW COVER

With the April issue, the old buff cover—which had been a Society trademark since the turn of the century—gave way to a more modern dress. During the past several decades, most medical journals have adopted more modern type design and layout. The committee is currently deciding whether a change for our publication would be healthy. In any event—as it was pointed out in an editorial in the April issue—"this is an external change only. The spirit remains unaltered, and THE JOURNAL will continue to serve you as a combination postgraduate course, news medium, house organ, and binding tie among our statewide membership."

The committee is confident that the increase in advertising and subscription rates—in addition to other possible changes—will make it possible this coming year for THE JOURNAL to pay for itself. Thus, it makes no request for budgetary appropriations. In some past years, our advertising income has exceeded publication costs. One year (1957) it was even possible for THE JOURNAL to turn over $5,000 to the Medical Student Loan Fund. If advertising income continues to fall, we hope to balance this, if necessary, with a proportionate reduction in text material.

Approved (page 338)

SUPPLEMENTAL REPORT

Frank L. Rosen, M.D., Chairman, Maplewood

Henry A. Davidson, M.D., Editor, Cedar Grove

Our primary report indicated that THE JOURNAL is running at a deficit. It neglected to point out that every state medical journal in our circulation bracket runs at a deficit. Ohio has a $48,000 deficit for 1962, and its House of Delegates voted a $50,000 subsidy to cover it. North Carolina had a deficit of $23,781, and its House allocated $23,781 to the Publication Committee to cover that. Indiana charges $8 a year subscription, and this amount is taken from each member's dues and allocated to its journal. Michigan does the same at $4 a member.

We are the only state medical journal in our circulation bracket which does not get a subsidy, either directly or by way of a subscription allocation from dues.

The Publication Committee asks the House to do two things:

1. Allocate to the Publication Committee an amount equal to $5 per member. The Board of Trustees, in January 1963, set that amount as a fair subscription rate. We do not ask that such funds be actually paid into the JOURNAL account. We ask simply that, in calculating the JOURNAL's financial posture, a credit of $5 a member be allotted.

This will bring us in line with what other state journals do.

Disapproved. Because the committee is in a state of transition, the reference committee felt that more time should be allowed—due to the projected increase in advertising rates and subscriptions, effective June 1, 1963—before any definite recommendation can be made as to a future course concerning the finances of THE JOURNAL. (page 338)

2. The Editor's salary should be charged against the JOURNAL. So should the *pro rata* share of the Assistant's Editor's salary. The Executive Director should determine what proportion of the Assistant Editor's time is reasonably charged to the JOURNAL, and that ratio of her salary should be counted as a JOURNAL expense.

Adopted (page 338)

REVISION OF CONSTITUTION AND BYLAWS

Louis F. Albright, M.D., Chairman, Spring Lake

(Reference Committee on Constitution and Bylaws)

APPLICATIONS FOR MEMBERSHIP

The 1962 House of Delegates referred the problem of applications for membership to the Committee on Revision of Constitution and Bylaws for timely changes in the method by which members are accepted or rejected into the component society and the parent Medical Society of New Jersey.

Following review of the background of the problem as contained in the 1962 Transactions —page 355, item from report of the Board of Trustees which was adopted; and page 410, resolution #1 from the Hudson County Medical Society which the House disapproved —the committee agreed that clarification concerning applications was needed in the Bylaws to eliminate future misinterpretation.

The following proposed amendments to the Bylaws were prepared by the committee for the consideration of the 1963 House of Delegates, and, in accordance with the provisions of Chapter XII of the Bylaws, were transmitted to the component societies on February 15, 1963:

CHAPTER IX — ADMINISTRATIVE COUNCILS AND COMMITTEES

Section 10 — Committee on Credentials

Current

(c) The Committee on Credentials shall review and act upon all applications for membership in component societies. It shall report its actions in writing to component societies.

Proposed

(c) The Committee on Credentials shall review and pass upon the formal credentials of all applicants for membership in component societies. It shall report its findings in writing to the component society concerned.

Adopted (page 335)

CHAPTER XI — COMPONENT SOCIETIES

Section 2 — Qualifications of Members

Current

(a) Each component society shall judge the qualifications of its applicants for membership, but election to any type of membership shall be contingent upon review and approval by the Committee on Credentials of this Society.

Proposed

(a) Component societies shall have the responsibility to judge the qualifications of an applicant for any type of membership and alone shall have the power to elect him, but election thereto shall be contingent upon clearance of each eligible applicant's formal credentials as satisfactory by the Committee on Credentials of this Society.

Adopted (page 335)

SIGNATURES ON CHECKS

The Board of Trustees adopted a motion "that in the absence of the Treasurer the

President be authorized to sign checks." The constitutionality of the action was questioned by the Treasurer, and the Board then referred its action to this committee for proper amendment of the Constitution and Bylaws.

Section 4, Chapter VI of the Bylaws, requires that the Treasurer be bonded and that he "shall preserve all funds of this Society," and further that he "shall not pay money out of the treasury except . . ." Counsel observed that by these provisions, the Society places careful limitations and restrictions upon the Treasurer which are not imposed upon the President.

Section 5, Chapter VI of the Bylaws, gives the Board of Trustees the power to "make suitable provision for the efficient conduct of the business of this Society." Counsel observed that although it would appear that the Board does have the power properly to determine who shall sign checks and the designation of the President to sign does not per se violate the Bylaws, it would appear to be unwise action in view of the fact that he is not bonded and there are no restrictions placed upon him with regard to paying out the Society's money; and "most important, it would place the Treasurer in the unenviable position of endeavoring to fulfill his requirements to preserve the Society's funds while not holding all the purse-strings."

It was noted that the Bylaws also require the bonding of the chairman of the committee on Finance and Budget.

The committee unanimously agreed that it would report to the Board of Trustees that it saw no necessity for modifying the Constitution and Bylaws, and that it would recommend: (1) That the Board rescind its action designating the President to sign checks; and (2) That the Board take a substitute action naming the chairman of the Committee on Finance and Budget (inasmuch as he also is bonded) as Acting Treasurer to serve at such intervals as the Treasurer is protractedly unavailable (meaning more than two weeks).

The Board of Trustees approved the committee's report, rescinded its previous action, and named the chairman of the Committee on Finance and Budget as Acting Treasurer.

Approved (page 335)

ADVISORY TO WOMAN'S AUXILIARY

Volmar A. Mereschak, M.D., Chairman, Phillipsburg

(Reference Committee "H")

The work of the Advisory Committee to the Woman's Auxiliary was minimized throughout the year because of the orderly procedures and cooperative attitudes that characterized the operations and activities of the Woman's Auxiliary. The Advisory Committee extends its thanks and congratulations to the officers and members of the Woman's Auxiliary who worked so hard to achieve a successful year.

Following the precedent of other years, at the beginning of the administrative year the official programs and projects for the year were submitted and cleared through the Board of Trustees.

The programs of the Woman's Auxiliary are all intended to serve in a supporting capacity the programs and purposes of The Medical Society of New Jersey and its component societies. As part of its program, the Auxiliary cooperated with the Medical Society's Special Committee on the Chronically Ill and the Aging, by participating in approved projects and programs and offering assistance to component medical societies in areas of public relations and legislation relevant to the care of the chronically ill and the aging.

In another area, too, special efforts were made to enhance the cause of civil defense by supporting programs of health mobilization and recommending specific literature on civil defense efforts. Also, to further the cause of medicine, the Auxiliary has kept its members fully informed of legislative material which was referred by the Council on Legislation of The Medical Society of New Jersey and has supplied informative material for use in its public programs.

The cooperation and joint efforts of The Medical Society of New Jersey and its Woman's Auxiliary make a strong organization which can and will accomplish the goals it has set for the good of the people and the medical profession in this State.

Approved (page 350)

LEGISLATION

Jesse McCall, M.D., Chairman, Newton

(Reference Committee "E")

Presentation of this report poses something of a problem every year, because while we in the Society are reporting on a full administrative year and are trying to make a complete package of our recorded materials, the Council on Legislation necessarily is presenting a mid-term report of legislation for the calendar year. The legislative year begins with the second week in January, and it continues until the date agreed upon by both houses for their *sine die* adjournment the following year. At the time at which this report is presently before the House, the New Jersey Legislature is in mid-course for 1963. Therefore, some of the items dealt with here were acted upon by the legislature before the final adjournment in 1962. Other legislative items have been introduced since the beginning of the 1963 session and continue to be a matter of consideration and concern at the present time.

The volume of bills to be considered by the council increases each year. In the first meeting of the council this year, the members were called upon to consider as many bills as had been dealt with in the entire legislative year preceding. For this reason, as chairman of the council, I wish to record my deep gratitude to the members of the council for their faithful and diligent work in behalf of the Society in this most important area of its operations.

CHIROPODY LAW

Since last summer, representatives of MSNJ met with the Governor's personal counsel and representatives of the chiropodists, in an attempt to evolve a satisfactory bill to extend the scope of the practice of chiropody. Those conferences were held in the expectation that an agreed-upon version could be adopted that would be acceptable to both sides. In its final form (S-13 of 1962) the measure had elements to which MSNJ objected strongly. However, this version represented a marked reduction of the chiropodists' original legislation and a limitation of their procedures to a minor fraction of what they originally wanted. The Society's representatives had done a great deal to accomplish what they thought was best for the practice of medicine and the public, and recognized that while the new law is not all that medicine wanted, it is far superior to what the chiropodists originally proposed and the best possible version obtainable under existing circumstances.

KERR-MILLS LAW

On January 14, 1963 Governor Hughes signed into law S-12 of 1962 (Chapter 222), thereby making available to the medical needy of New Jersey the assistance provided under the Kerr-Mills Law. We have consistently urged legislation of this type, in order to make available a medical assistance program for residents of New Jersey who have attained the age of sixty-five years and who have not sufficient personal or family resources to meet the costs of necessary health services. At the present time the administration is working on details of this program, in the hope of putting it in operation as of July 1, 1963.

PROFESSIONAL SERVICE CORPORATIONS

On February 4, 1963—in the presence of our President, Doctor Wegryn—Governor Hughes signed S-32 of 1962 into law (Chapter 233), effective immediately. This law authorizes the creation of professional service corporations. Physicians are included within the purview of this act.

MEDICAL TECHNICIANS

We have also been strongly supporting the amendment to the Medical Practice Act that would extend legal protection to medical technicians and x-ray technicians acting at the specific direction of licensed physicians (S-138 of 1963). We have not as yet had the satisfaction of seeing this measure move appreciably toward adoption. At the present time, it has been reported out of committee and given second reading in the Senate. We will

continue our efforts, and we hope that all members of the Medical Society and our cooperating agencies will continue to urge the adoption of this measure on the Legislature.

SCHOOL EXAMINATION LAW

In preceding legislative years we caused to be introduced, and supported for passage, legislation which would permit a school medical inspector to accept evidence of a satisfactorily performed physical examination in lieu of the school examination required under present law. This year the council felt that it would not continue the same pressure on this legislation directly, but would work to see if we could overcome areas of opposition that have thus far successfully discouraged its passage in the legislature.

It is the policy of the Council on Legislation—approved by the Board—to avoid simultaneous introduction of numerous bills in the legislature, because experience has taught us that the chances of success are greater if we have a few bills that we watch carefully and constantly urge the members of the legislature to support.

MEDICAL-SURGICAL PLAN

We have cooperated with Medical-Surgical Plan in urging the passage of those legislative measures that would be acceptable to, and consonant with, the progress and development of the Plan, and in resisting the passage of those bills that would impede its continued successful operation.

"GOOD SAMARITAN"

The council reports with satisfaction that a bill to protect from liability any person licensed to practice any method of treatment of human ailments who in good faith renders emergency service (A-62) has passed both houses and is currently awaiting the Governor's signature. A-62 is identical with a bill drafted by the council and approved by the Board in 1962.

EYE BANKS

The council also reports, as being of particular interest, that a bill has been passed in the Assembly (A-547 of 1963) which would provide for the willing of eyes for the purposes of transplanting to other human beings. The council has drafted proposed legislation to enable one to will not only his eyes for scientific work, but the entire body or any member or part thereof. It is the council's hope that A-547 will be expanded to include the entire body, or that after enactment of A-547 it may be possible to amend it satisfactorily to include all bodily parts. A-547 passed in the Assembly on April 1.

CURRENT STATE LEGISLATION

Since the opening of the 1963 State Legislative Session on January 8, the council has considered the following bills, each carefully analyzed by its Legislative Analyst. All measures thus marked (*) are identical with bills of 1962 or preceding years, and the official position of The Medical Society of New Jersey concerning them remains the same. For the information of the House, the council takes this opportunity to review its regular range of positions:

Active Support . . . all-out support for the measure;

Active Opposition . . . all-out opposition to the measure;

Approval . . . commended as satisfactory but not actively supported;

Disapproval . . . rejected as unsatisfactory but not actively opposed;

No action . . . considered but not regarded as significant or relevant to the Society's interests at this time.

(Positions of active opposition and disapproval are always accompanied by a statement of reasons.)

*S-1 —To provide for the formation of non-profit dental service corporations and the operation and regulation of Dental Service Plans. *No Action*

*S-4 —To authorize medical service corporations
*A-328—to include in their contracts a subrogation provision in the event a subscriber or eligible dependent receives payments for injuries resulting from the negligence or wrongdoing of a third party. *Approval.*

*S-5 —To permit a medical service corporation
*A-326—to file and enforce a lien when it has made payment to a physician for services rendered and to provide for the reimbursement of the medical service corporation by the physician in the event the lien is paid. *Approval*

*S-6 —To give the Commissioner of Banking and
*A-330—Insurance authority to disapprove practices, rules and procedures of a medical service corporation where he feels they are unjust, unfair, or inequitable. *Active Opposition* . . . because, in contravention of the public interest, these measures would unwarrantedly grant the Commissioner of Banking and Insurance dictatorial powers that would invade and usurp the normal functions and discretion of the board of trustees of a medical service corporation and would thus threaten the continuance of operation of such medical service corporation in this State. (Action Bulletin sent February 7, 1963)

*S-7 —To allow medical service corporations to
*A-331—enter into agreements with other corporations to underwrite group contracts covering employees outside the State. *Approval*

*S-8 —To permit medical service corporations to
*A-329—provide group contracts covering at least 100 employees or members based upon experience rated premiums and to levy an annual supervisory fee of $20,000 on such corporations. *Approval*

*S-9 —To permit medical service corporations to
*A-306—issue master group contracts to employees and other policy holders. *Approval.*

*S-10 —To permit hospital service corporations to
*A-337—provide group contracts covering at least 100 employees or members based upon experience rated premiums and to levy an annual supervisory fee of $20,000 on such corporations. *Approval*

*S-11 —To allow hospital service corporations to
*A-333—enter into agreements with other corporations to underwrite group contracts covering employees outside the State. *Approval*

*S-12 —To permit hospital service corporations to
*A-335—issue master group contracts to employees and other policy holders. *Approval*

*S-13 —To give the Commissioner of Banking and
*A-334—Insurance authority to disapprove practices, rules and procedures of a hospital service corporation where he feels they are unjust, unfair, or inequitable. *Disapproval* . . . in consistency with our active opposition to its companion bill affecting Medical-Surgical Plan.

*S-14 —To permit hospital service and medical
*A-327—service corporations to issue a combined contract providing for hospital and medical care. *Approval*

*S-15—To permit hospitals to enforce liens for
*A-325—services rendered notwithstanding any portion of such charges being paid by a non-profit hospital service corporation and to provide for reimbursement of the hospital service corporation in the event the lien is paid. *Approval*

*S-16—To authorize hospital service corporations
*A-336—to include a subrogation provision in their contract. *Approval*

*S-17 —To amend the Charter and by-laws of the
*A-332—Hospital Service Corporation of New Jersey to provide for the appointment of 9 public trustees by the Governor with the advice and consent of the Senate, to include three from organized labor and six public. *Disapproval* . . . in support of the position of opposition of the New Jersey Hospital Association.

S-35 —To require the installation of seat safety belts on automobiles registered in the State after July 1, 1965. *Approval*

S-37 —To delete the requirement in the motor vehicle laws that a specimen for drunk driving test must be expressly consented to and substitute a ban on taking such a specimen forcibly. *Disapproval* . . . because the standard of determination of "drunken driving" used is unrealistically high, and MSNJ supports a standard of .10 per cent.

S-38 —To revise the penalties for driving while
A-46 —under the influence of alcoholic beverages. *Disapproval* . . . because the standard used is unrealistically low, and MSNJ supports a standard of .10 per cent.

S-46 —To amend the State Employees Health Benefits Act of 1961 to permit counties, municipalities, school districts and other public agencies to elect to participate in health benefit programs and provide coverage for their employees and their dependents. *Approval*

*S-57 —To provide that certain notices of hospital
*A-136—and medical liens may be filed in the county clerk's office within 90 days after the first day of treatment. *Approval*

*S-62 —To define "accident" under the Workmen's
*A-200—Compensation Law to mean an unusual event occurring in the employment environment, other than a physical change in the employee. *Approval*

S-72 —To permit local boards of education to send children to private schools providing services for emotionally disturbed or socially maladjusted children if no suitable

public school placement is available. *No Action*

S-76 —To authorize county boards of freeholders to make appropriations for the treatment of mentally ill children by certain approved non-sectarian and non-profit private organizations. *No Action*

*S-77 —To prohibit the practicing of optometry in retail stores or offices not exclusively devoted to that practice. *No Action*

*S-83 —To revise certain qualifications for persons to be admitted to examination for license to practice medicine and surgery. *Active Opposition* . . . because it would circumvent the lawful procedure for the licensing of a physician adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. Thus it is contrary to the public interest and unfair to all those physicians who are legitimately and properly licensed by the State of New Jersey through the functions of the Board of Medical Examiners.

*S-85 —To increase allowances for reimbursement
*A-364—from federal and state funds for community mental health projects. *No Action*

*S-103—To provide that services performed by a duly registered bio-analytical laboratory are within the scope of medical service plans. *No Action*

S-118 —To authorize hospital service plan coverage of health care services by voluntary non-profit visiting nurse organizations elsewhere than in a hospital. *Approval*

S-124—To authorize charges for diagnostic services and treatment at county mental centers or institutions. *Approval*

S-135—To broaden the protection afforded employers in second accident prior disability cases under the Workmen's Compensation Act. *Approval*

*S-138—To exempt certain medical and x-ray technicians from the scope of the Medical Practice Act. *Active Support* (sponsored by MSNJ)

*S-143—To define the practice of chiropractic as "a system of adjusting the articulations of the spinal column and related tissue by manipulation thereof." *Active Opposition* . . . because it is an unwarranted extension of the scope of the practice of chiropractic; and would give responsibility and privilege in areas for which chiropractors are not competent.

*A-36 —To make the requirement that containers shall be marked with the date of pasteurization, applicable to cream. *Disapproval* in conformity with the opinion of the U.S. Department of Health, Education, and Welfare that "the disadvantages are more significant than any advantages that may now be claimed for the dating of pasteurized milk" and in support of the contention of the Department of Health that the bill is not warranted or necessary.

*A-38 —To provide for the registration and examination of dental laboratory operators and their assistants by the State Board of Registration and Examination in Dentistry. *Disapproval* . . . in support of the position of the New Jersey State Dental Society which contends that the bill is loosely drawn.

A-39 —To authorize the temporary commitment of drug addicts to the New Jersey Neuropsychiatric Institute. *No Action*

A-40 —To provide that patients may be admitted to the New Jersey Neuropsychiatric Institute by order of a court on conviction of a crime or before being charged with a criminal offense. *No Action*

*A-62 —To exempt licensed medical practitioners from civil action arising out of emergency care at the scene of an accident. *Approval*

*A-79 —To permit an injured employee to select the physician he wishes to treat him under the Workmen's Compensation Act. *Approval*

*A-111—To revise generally the laws dealing with mental health and mentally retarded persons—an Act to be known as the "Mental Health Act 1963." *Approval*

*A-112—To establish the power of the State Board of Institutions and Agencies to classify the functions and establish specialized facilities, and services of various institutions. *Approval*

*A-113—To make technical amendments in various statutes dealing with mental incompetents and their guardians. *Approval*

*A-144—To limit the time for bringing actions at law by parents or guardians on behalf of minors under the age of 21 derived by reason of an injury to such minor. *Approval*

A-164—To permit non-profit hospital corporations to receive wage assignments in return for care or treatment to patients. *No Action*

A-190—To increase the penalties for violation of the narcotics laws. *No Action*

*A-193—To provide that data in possession of the State Department of Health, pertaining to the health of any named person, procured

in connection with research studies, approved by the Public Health Council, for the purpose of reducing the morbidity or mortality from any cause or condition of health shall be kept in confidence by the Department except to persons participating in research study or in such impersonal form that the individual concerned cannot be identified. *Approval*

A-196—To permit the renewal of certain limited partnership associations and establish a procedure for same. *No Action*

*A-199—To limit the subrogation rights of insurance companies, or medical or hospital service corporations with respect to third party recoveries for hospital or medical services. *Disapproval* . . . in consistency with our approval of S-4 and A-328.

A-243—To grant certain exemptions from specific requirements for physicians' licenses to M.D.'s on the staff or a state or county agency. *Approval*

*A-244—To establish the procedure for the Banking and Insurance Commissioner to disapprove rates of medical service corporations and for court review thereof. *Active Opposition* . . . because it would empower the Commissioner of Banking and Insurance to fix fees to be paid by MSP to participating physicians and would therefore constitute an unwarranted and unjustifiable denial of the fundamental right of of the physician to set his own fee for professional services rendered, thus threatening the operation of the Plan, in disregard of the best interests of the approximately two million people of New Jersey who are its subscribers.

A-287—To revise the definitions and regulations concerning boarding homes for the sheltered care of adults. *Action Deferred* . . . pending study and report by the Special Committee on the Chronically Ill and the Aging, to which the council referred the bill.

A-288—To include "rest homes" under the regulations affecting nursing homes and private hospitals and make certain other changes in that law. *Action Deferred* . . . pending study and report by the Special Committee on the Chronically Ill and Aging, to which the council referred the bill.

A-313—To grant to married minors and unmarried pregnant women who are minors the legal right to consent to the performance of hospital, medical, or surgical care. *Approval*

*A-316—To increase the penalties of certain narcotic violations and to forbid suspension of sentences. *No Action*

*A-317—To provide a prison term of not less than 20 years for hiring or use of any child under 18 years of age in illegal sales or transactions of certain narcotic drugs. *No Action*

*A-318—To provide that no person other than a pharmacist, shall sell any preparation or mixture or compound or drugs containing codeine or any barbiturate to any person under the age of 21, except upon a written prescription of a physician, dentist, or veterinarian. *Disapproval* . . . until recommendations for broadening the prohibition are included.

*A-319—To make possession by unauthorized persons of certain barbiturates, hypnotic and tranquilizing drugs, without a prescription, a disorderly persons offense. *Approval*

*A-320—To forbid the suspension of any sentences for the illegal manufacture or sale of narcotic drugs. *No Action*

A-338—To extend the time for filing petitions under the Workmen's Compensation Act in cases of exposure to ionizing radiation. *Approval*

A-340—To authorize the joint underwriting of health insurance for persons 65 and over and to provide the premiums received for such policies shall not be included in determining certain taxes on insurance companies. *No Action*

A-341—To transfer certain approval powers over hospital service corporations from the Commissioner of Institutions and Agencies to the Commissioner of Banking and Insurance. *No Action*

*A-361—To prohibit the discharge of sewage into State waters from boats except through certain prescribed marine toilets. *Approval*

A-364—To increase allowances for reimbursement from Federal and State funds for community mental health projects. *No Action*

A-378—To forbid hypnotizing as a form of entertainment. *Approval*

A-440—To amend the Uniform Narcotic Drug Law with respect to Narcotic Prescription Forms. *Disapproval* . . . because it is unnecessary and unrealistic, and places a burden on the general public to protect itself against forgers and counterfeiters.

At a meeting on April 10, 1963, the council considered the following measures and recommended the indicated positions. These recommendations are to be considered by the Board

at its own meeting on April 21, and any modifications of the positions set forth below will be reported to the House in the supplemental report of the Board of Trustees.

S-160—To amend Chapter 51 of the laws of 1960
A-591—concerning the taxation of tangible personal property used in business to provide that such assets may be fully depreciated according to Federal income tax rules and that the taxable value of such property shall be one-fourth the common level of real property. *Approval*

S-162—To provide specific revocation penalties for minor drivers operating vehicles while under the influence of alcohol according to the alcoholic content of the defendant's blood. *Disapproval . . .* because MSNJ supports .10 per cent as the standard of determination, and this bill uses .05 per cent.

S-169—To require that contracts of medical service plans must contain a statement that the amounts payable to the corporation may be changed at any time upon 90 days' written notice to the subscriber. *Approval*

S-173—To revise the provisions of law regulating the registration of physical therapists. *Approval*

S-175—To revise the standards for measuring alcoholic content in a defendant's blood under the drunk driving law. *Approval*

S-181—To require the licensing of blood banks and to regulate their operation. *Approval*

S-191—To authorize certain non-profit corporations to provide certain dental care facilities and services. *No Action*

S-197—To provide that Hospital Service and Medical Service Corporations may be sued in civil actions in a county district court. *Approval*

S-199—To permit the employment of certain technical personnel in the offices of chiropractors. *No Action*

*S-206—To define the terms "patent or proprietary
*A-589—medicines" and "non-poisonous" in connection with sales of over-the-counter drug items. *Disapproval . . .* because the council is of the opinion that Section 2 of this measure empowers the manufacturer to determine what is non-poisonous. This section declares: ". . . the term 'non-poisonous' shall mean and include those preparations which are not dangerous to health when used in the dosage, or with the frequency or duration prescribed, recommended, or suggested in the labeling thereof." The council considers that it is unwise and undesirable and contrary to the public interest that the manufacturer be the sole arbiter of what is "non-poisonous." Moreover, MSNJ looks with disfavor on any legislation which would relax the salutary controls necessary for the protection of the public and which would tend to encourage self-medication on the part of the public.

*S-209—To permit county hospitals to accept private patients who cannot obtain admission within a reasonable time to a voluntary hospital in a county. *No Action*

S-239—To increase workmen's compensation benefits and to revise generally the state's Workmen's Compensation Act. *Action Deferred . . .* pending study and recommendations by the Special Committee on Workmen's Compensation.

S-244—To re-define the term "milk" under the Food and Drug Law, to "contain not less than 3 per cent milk fat and not less than 8¼ per cent milk solids not fat." *No Action*

A-411—To repeal the law requiring migrant laborers to submit to examination for venereal diseases. *Action Deferred . . .* pending receipt of further information.

*A-456—To prohibit the discharge of pollutant matter or materials into inland tidal waters and to regulate the operation of toilet facilities in vessels in said waters. *Approval*

*A-476—To provide that any condition or impair-
*A-478—ment of health to firemen and policemen caused by hypertension, heart disease, or tuberculosis shall be deemed to be an occupational disease. *Disapproval . . .* because they involve diagnosis by legislative enactment rather than by medical investigation.

A-483—To repeal all portions of Chapter 51, Laws of 1960, concerning property taxation except those affecting household goods. *Disapproval . . .* in consistency with support of S-160.

A-489—To amend the law providing for the licensing and regulation of hospitals and nursing homes to remove the restriction forbidding the Department of Institutions and Agencies to deny an application for license or approval on the sole ground that adequate hospital or nursing home facilities are already available in the area. *Action Deferred . . .* pending further study.

A-498—To revise the requirements of the laws regulating nursing homes and private hospitals as they pertain to "boarding

homes for sheltered care." *Action Deferred . . .* pending further study.

A-499—To define "resident" of a boarding home for sheltered care and permit standards to be fixed by the State Board of Control of the Department of Institutions and Agencies, upon recommendation by the Hospital Licensing Board. *Approval.*

A-506—To require the use of humane methods in the slaughter of livestock. *No Action*

A-527—To require that certain items or medicinals or classes of items or medicinals can only be sold at retail in pharmacies, and to expand the authority of the State Board of Pharmacy. *Approval*

A-547—To provide for the willing of eyes for the purposes of transplanting to other human beings. *Approval*

A-548—To revise and clarify the laws concerning the sale of packaged drugs and medicines which are sold to the general public in stores other than pharmacies. *Disapproval . . .* because it would encourage self-medication.

A-549—To require a physician's report in connection with application to carry a firearm. *Disapproval, with active opposition if bill moves . . .* because it would impose upon the physician a responsibility of determination which could be only supported by an extensive and detailed series of tests and examinations, and because it also would expose the physician unnecessarily to liability for possible subsequent violent accidents or incidents involving individuals thus granted permits.

A-575—To mandate boards of education to require physical examinations of their school bus drivers. *Approval*

A-576—To include respiratory diseases under the
A-577—disability provisions of certain members of
A-578—the fire and police departments, under certain conditions. *Disapproval . . .* because they involve diagnosis by legislative enactment rather than by medical investigation.

A-598—To forbid the "grooving" of motor vehicle tires and the sale of such tires. *Approval*

A-621—To regulate and license the collection and disposal of solid waste to create a Division of Refuse Control in the State Department of Health and an advisory council to said division. *Disapproval . . .* in support of the position of the State Department of Health that the legislation is unnecessary and undesirable.

A-629—To amend the provisions of the welfare laws dealing with assistance for the blind to make certain changes concerning the eligibility for care in certain medical institutions. *Approval*

A-638—To amend the Medical Practice Act to exempt assistants of persons who are licensed as osteopaths, chiropractors, optometrists, or other practitioners holding limited licenses. *No Action*

A-656—To authorize county boards of freeholders to appropriate funds for non-profit organizations operating facilities for the treatment and training of the mentally retarded and physically handicapped. *Approval*

A-663—To revise the statute creating the Division of Aging with respect to the office of Director and the Commission on Aging. *Action Deferred . . .* pending further study.

NATIONAL LEGISLATION

In consequence of its preoccupation with the Administration's proposals for tax reduction, Congress has not yet turned its attention actively to the Administration's proposals for the provision of health care services for people over age 65 by means of the extension of Social Security. The AMA has analyzed and reported upon the new King-Anderson Bill (Senate 880 and House of Representatives 3920). Our activities as regards these and related measures will be determined by the subsequent developments in Washington.

Approved (page 342)

1962 TRANSACTIONS

At its first session on Saturday afternoon, May 11, 1963, the House of Delegates **approved:**

The Transactions of the 1962 House of Delegates as published in the July 1962 JOURNAL and distributed to the membership.

PUBLIC RELATIONS

John F. Kustrup, M.D., Chairman, Trenton

(Reference Committee "E")

In fulfilling its function to "evaluate, suggest, and—with approval—carry out programs and projects calculated to further the public relations of this Society," the council has continued successfully all its regular operations, including the following:

JUNIOR HEALTH HINTS

Series four, published in booklet form, was distributed to teaching personnel at junior and senior high school level upon request. In making provision for next year, the council concluded that the current series has proved so popular and of such value, it would be difficult —if not impossible—to improve upon it or to initiate a new series that would be as effective. It has agreed, therefore, to repeat the entire series (one through four) sequentially over the next four years, with such revisions as may be indicated to keep the contents current.

The council reports the general satisfaction of teaching personnel with this teaching aid. Each booklet will continue to contain thirty-two articles to serve as the bases for thirty-two sessions of classroom instruction, one period a week through the school year.

HEALTH HINTS

Health Hints are a fortnightly feature, published and distributed over the name of Michael S. Newjohn, M.D., to daily and weekly newspapers, house organs, and others upon request. This service likewise retains general favor with its regular users.

MEMBERSHIP NEWS LETTER

In an effort to bring to the members those day-by-day items of significance, eight separate issues of the *Membership News Letter* were distributed. Last summer was also inaugurated the distribution to each component society, for its ready reference, an indexed compilation of the year's issues of the *Membership News Letter*.

GOLDEN MERIT AWARD

The council is pleased to report that with each passing year the Golden Merit Award gains in popularity and proves ever to be a source of heart-warming gratification to its recipients and their families, as well as to all of the Society connected with its presentation. Inaugurated in 1957 to give deserved recognition and honor to members of MSNJ who have held the degree of Doctor of Medicine for 50 years or more, the Golden Merit Award will have a new feature this year. Recipients and their families present in Atlantic City will be guests at a social affair, hosted by Officers of the Society, members of the Board and the Council on Public Relations, and presidents of component societies whose members are being honored.

In 1962, there were 35 recipients of the award—16 of whom were present in Atlantic City. This year, there are 29 candidates eligible to receive the award.

PERIODIC NEWSLETTER

Because of the relatively quiescent state of national legislation affecting medical interest, it has not been necessary this year (as it was in the administrative year 1961-62) to bring out any issues of the *Periodic Newsletter* or to produce a special pamphlet similar to the one the Society compiled in 1962, "A Free America or a Welfare State." The council continues to follow closely the developments in the national area of legislation and is prepared to step up the tempo of its activities as circumstances warrant.

CHILD SAFETY WEEK

In cooperation with the Special Committee on Child Health, the council supplied a series of articles and releases to component societies for use at county level in conjunction with "Child Safety Week" in New Jersey. With the cooperation again this year of the Governor, the council also was instrumental in the issuance of a formal proclamation declaring the week of April 1-6 as "Child Safety Week."

SPECIAL NEWS RELEASES

The council issued many separate releases in support of:

1962 Annual Meeting . . . resulting in 709 separate articles (430 of which were out-of-state), including 27 editorials and 39 pictures.

1962 Eye Health Screening Program . . . resulting in 184 separate articles, including 7 pictures and 2 editorials.

Kerr-Mills Law . . . commending the Governor for signing S-12 (of 1962) into law on January 14, 1963.

ANNUAL MEETING PRESS ROOM

As has been its custom for many years, the council will sponsor a press room at the annual meeting. It will be located in the Sun Porch on the Lounge floor of Haddon Hall. Spot news releases and interviews are arranged through this unit. Advance materials are mailed from the Executive Offices.

Approved (page 342)

MEDICAL SERVICES

Irving Klompus, M.D., Chairman, Bound Brook

(Reference Committee "F")

The activities of the Council on Medical Services this year have centered on (1) concerns of the council proper; (2) Public Medical Care as dealt with by a subcommittee chaired by Dr. Raymond J. Germain; and (3) Physician-Hospital Relationships, dealt with by a subcommittee chaired by Dr. Francis J. Benz.

CONCERNS OF COUNCIL PROPER

The council considered the reports and working progress of its Special Committees on Workmen's Compensation and Occupational Health. The details of their activities are contained in their respective reports.

At the request of the New Jersey State Funeral Directors' Association, and at the direction of the Board of Trustees, the council cooperated in the drafting of "Recommended Procedures in Hospital Deaths," the final copy of which was approved for use as a guide. The New Jersey Hospital Association and the New Jersey Society of Pathologists also cooperated in the preparation of this material, and the Recommended Procedures were recently published, crediting the four organizations, and distributed by the Funeral Directors' Association.

The Board of Trustees approved the council's recommendation that there be no interference with the physician's judgment as to quantities of tranquilizers and barbiturates prescribed as suggested by the Special Committee on Child Health in its consideration of the subject of a recent White House Conference on narcotics and drug abuses.

On referral from the office of the Secretary, the council considered a complaint regarding non-participation of anesthesiologists in the New Jersey Blue Shield Plan.

It was the feeling of the council that improvements in the economics of Blue Shield in relation to anesthesiologists might increase their participation, and the council referred the complaint to the New Jersey State Society of Anesthesiologists.

Recommended that the Council continue with projects of this kind and pursue them to conclusion. (page 343)

PUBLIC MEDICAL CARE

During the 1962 annual meeting the Subcommittee on Public Medical Care met with representatives of the State Division of Welfare. At this and subsequent meetings it was agreed that:

1. Drugs to public assistance recipients may not be dispensed after an interval of seven days from prescription date unless the doctor has been contacted (by telephone).

2. If specified by the doctor, payments may be made for dietary reducing preparations.

3. Prescription forms would be in quadruple copies on carbon impregnated paper on which the physician is required to sign only once.

4. Single monthly billings would be permissible with a specified number of visits without authorization—tentatively limited to five visits per month for acute illness and exacerbation of a chronic illness, and 2 visits per month for chronic illness.

Approved. Recommended that each County Welfare Board be made aware of the items as specified in this section of the report. (page 344)

PHYSICIAN-HOSPITAL RELATIONSHIPS

At the request of President Wegryn, the Council on Medical Services received an assignment from the Board of Trustees to study physician-hospital relationships in New Jersey and set up a recommended guide of relationships between the two. Material on this subject from national and state organizations was obtained and reviewed. A subcommittee of the council was appointed to draft a guide for New Jersey based on the following points:

1. Responsibility of the physician to the hospital.
2. Responsibility of the hospital to the physician.
3. Relationship of the various specialties to the hospital and to other physicians.
4. Relationship of the physician to the patient in or out of the hospital.

Five meetings of the subcommittee were held, and "Guides for Physician-Hospital Relationships in New Jersey" were drafted, covering such broad points as:

1. Hospital Medical Staff.
2. Relation of Physician to Intern or Resident.
3. Medical Staff Appointment.
4. Remuneration of the Physician by a Hospital.
5. Grievance Procedures.
6. Physician-Hospital Financial Arrangements.

The draft of the Guides has been submitted to the Board of Trustees for consideration and, we hope, clearance for conferences with other interested groups, such as the New Jersey Hospital Association. In their final form the Guides will be submitted to the House of Delegates.

Accepted as progress report (page 344)

Approved (page 344)

Special Committees to the Administrative Council on Medical Services • • •

OCCUPATIONAL HEALTH

Delma W. Caldwell, M.D., Chairman, Linden

(Reference Committee "F")

On recommendation of the committee, and with the approval of the Board of Trustees, the name of the Special Committee on Industrial Health was changed to "Special Committee on Occupational Health" in conformity with the designation used by the AMA.

The Special Committee on Occupational Health continued its study of the possibility of publishing a pamphlet on organization and operation of an industrial health program for distribution in New Jersey, as has been done in other states.

Representatives of the committee participated in the AMA Congress on Occupational Health, and the report of the Congress was carefully reviewed and studied by the com-

mittee members. The committee also met jointly with the Special Committee on Workmen's Compensation in its deliberations concerning the New Jersey Workmen's Compensation Law and the matter of free choice of physician in compensation cases.

A follow-up item on "Tetanus Immunization" was published in the March 1963 issue of The Journal, appealing to the membership to emphasize and carry out a tetanus immunization program.

The continuing work of the committee next year will be the preparation of articles of mutual interest (general rather than specific) to occupational and non-occupational physicians for publication in The Journal; completion of the pamphlet on organization and operation of various types of industrial health programs for distribution in New Jersey; and a marked effort to have members of the committee appear before county society meetings to talk on subjects being dealt with by the committee and to offer the committee's services to the component societies. The committee feels that a future area of development is in assisting component societies in industrial matters brought to their attention at local level.

As personal comment of the chairman, I feel that a great deal can be accomplished if, as representatives of this committee, physicians vitally involved in occupational health work would prepare articles for publication in The Journal and would offer their services to component societies as speakers on all phases of occupational health. I also personally feel that the chairmanship of a committee such as this for a period of not more than two years is advisable. A lesser period results in almost no time to complete assignments or projects, and a longer period tends to produce stalemates and an air of apathy toward proposed functions.

Adopted (page 344)

WORKMEN'S COMPENSATION

Joseph A. Lepree, M.D., Chairman, Elizabeth

(Reference Committee "F")

GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT

The AMA Guides to the Evaluation of Permanent Impairment of (1) the Cardiovascular System, (2) the Extremities and Back, (3) Ear, Nose, Throat, and Related Structures, and (4) the Visual System were studied by the committee and accepted as guides.

In the study of the guide on the Cardiovascular System, a joint meeting was held with the Special Committee on Occupational Health, with a consultant cardiologist present for the discussion.

NEW JERSEY LAW

Members of the Special Committee on Workmen's Compensation appeared before the Law Revision and Legislative Services Commission at the State House, Trenton, to present the views of The Medical Society of New Jersey, as regards the free choice of physician in the treatment of injured workmen. We were advised at that time by the legislators that The Medical Society of New Jersey should present a program for the implementation of the free choice of physician and any other recommendations for the treatment of injured workmen.

A meeting was subsequently held by the special committee, augmented by the President and representatives from the Board of Trustees. At this time recommendations were drawn up which were subsequently submitted to the Board of Trustees. These were accepted and amended by the Board of Trustees, and, in turn, submitted to the Secretary of the Law Revision and Legislative Services Commission of the State of New Jersey as follows:

The Medical Society of New Jersey observes that the problem of increased cost in New Jersey has been posed not by the cost of medical care—which in New Jersey is only one-third of the cost in New York State—but by costs which are attributable to administrative determinations and decisions. In this area it does not undertake to make official recommendations.

However, in the interest of further improving medical care under workmen's compensation and of controlling costs proper to it, The Medical Society of New Jersey respectfully recommends:

1. Injured employees should have the right to accept the services of fully licensed physicians and surgeons of New Jersey as provided by employers, or to select another fully licensed physician and surgeon of New Jersey who is willing and qualified to perform the essential services.

2. In the exercise of his choice of another fully licensed physician and surgeon of New Jersey, the patient shall be required to inform his employer of the name of such physician, but should the patient desire to change to a second physician in the course of his treatment permission must be obtained from his employer.

3. In order to assist the Deputy Commissioner in making his determination of the degree of disability in those cases in which there is marked discrepancy in the estimates of impairment, there shall be available to him qualified specialists in the particular field of medicine involved.

4. Medical testimony and statements with regard to the injured workman should be limited to an estimate of physical impairment. In explanation, the following is quoted from the official position of the American Medical Association (adopted December 1955), as contained in its report "Medical Relations in Workmen's Compensation":

Role of the Individual Physician . . .

The best interests of the disabled patient will be served in the following ways:

(d) Determination should be made by scientific methods and upon the basis of objective measurable factors of the permanent anatomic or functional impairment of a specified member or of his patient as a whole as compared to normal. From the medical standpoint, permanent anatomic or functional impairments cannot vary because of geographic locations or circumstances under which they were incurred. Therefore, the physician should determine the percentage of permanent impairment without regard to age, sex, occupation or real, presumed or potential wage loss. The application of these and all other factors provided by law to the percentage of permanent impairment established by the physician is the responsibility of the administrative agency in determining the indemnity award.

STATE EMPLOYEES

A Special Committee on State Employees and Workmen's Compensation—subsequent to a meeting with representatives of the Attorney General of the State, and approved by the Special Committee on Workmen's Compensation—resolved that the fee schedule submitted for the treatment of the State of New Jersey Employees would be accepted as a guide with the following changes:

1. The surgical fee shall not include the post-operative hospital visits.

2. Where there is need for a qualified assistant, he shall bill directly for his services—not to exceed 20 per cent of the surgeon's fee. This is not to be allocated against the surgeon's fee for surgery.

3. Application of casts shall be billed as separate procedures, with the exception of casts applied at the time of a major surgical procedure.

Any disputed bill shall be submitted to the workmen's compensation committee of the local county medical society for adjudication. These services are always available in such instances.

It should be noted that according to the Compensation Law of the State of New Jersey: "All charges, therefore, shall be reasonable, and based upon those that prevail in the same community for similar services." (Reference R.S. 34:15-15)

RECOMMENDATION

That the 1963-64 program of the Special Committee on Workmen's Compensation follow the lines of consultation, discussion, and recommendation with the State Department of Labor, the New Jersey Bar Association, representatives of insurance carriers, and other interested parties, with the aim of implementing and utilizing the Guides to the Evaluation of Permanent Impairment in an attempt to improve disability determinations and eliminate present inequities for the welfare of the patient.

Adopted (page 344)

PUBLIC HEALTH

John B. Fuhrmann, M.D., Chairman, Flemington

(Reference Committee "G")

The business of the Council on Public Health was expedited again this year by the adherence of the special committees to the regulation requiring their meetings at least two weeks prior to the meetings of the council. This insures that each member of the council will have a copy of the committee minutes prior to council meetings. This has proved to be the most expeditious rule adopted during my entire membership on any committee or council of The Medical Society of New Jersey.

The special committees have, as a whole, continued their excellent work, and complete details will be found in their separate reports. However, I feel that certain of the projects and ideas are worthy of additional mention.

1. The adoption of a state-wide Child Safety Program and the declaration of Child Safety Week by Governor Hughes.

2. The discussion of sepsis by the Maternal and Infant Welfare Committee and the planned preparation of an article on treatment of sepsis for THE JOURNAL.

3. The Symposium on School Health for New Jersey School Physicians and the initiation of steps to form an organization for School Physicians.

4. The implementation of the School Eye Health Program in a number of cities around the State.

5. The cooperation of the Committee on the Chronically Ill and the Aging with the Committee on Rehabilitation to determine facilities available in the State for care of these persons.

Again this year there have been projects undertaken by the council proper which are worthy of noting.

1. The co-sponsoring of a second seminar with the New Jersey Veterinary Medical Association, to discuss problems which are common to both Societies. The first seminar was a notable success.

2. The finishing of the problem concerning "Medic Alert." Last year, the council was asked to endorse this project for emergency medical identification. At that time we were awaiting an answer from the AMA which was investigating this problem. The AMA committee came to the decision that it would endorse no one method of emergency medical identification but would vouch for the authenticity of each type and supply a list of such methods as they deemed reputable. They supplied us with such a list and a form letter which explains their stand very nicely. The council endorsed the stand of the AMA on the problem of emergency medical identification devices and will so inform all organizations that apply to the Society for endorsement.

3. At our last meeting the subject of the relationship between cigarette smoking and lung cancer was brought up. It was felt by the council that some statement should be made by The Medical Society of New Jersey on this subject, but the actual framing of the statement was postponed pending receipt of similar statements from other organizations for comparision. It was the feeling, however, that we will in the next year make a statement of value on this subject.

Again this year we were very fortunate in having close liaison with the New Jersey State Health Department by having Doctor Roscoe P. Kandle, Commissioner of Health, as a member of the Council. His information on a wide range of subjects often eases the council's problems and, conversely, the information which he obtains from our meetings, I am sure eases his endless tasks a little.

May I offer my personal thanks to the many people who have cooperated this year with the Council on Public Health in our deliberations. Each has contributed greatly to whatever success we have obtained.

Approved (page 348)

Special Committees to the Administrative Council on Public Health • • •

CANCER CONTROL

John L. Olpp, M.D., Chairman, Englewood

(Reference Committee "G")

The Special Committee on Cancer Control conducted a survey of tumor registries in New Jersey hospitals. Questionnaires were sent to 100 community hospitals, of which 91 replied, providing the following information:

57 hospitals have functioning tumor registries

8 hospitals are in the process of organizing registries

26 hospitals do not have tumor registries

The Bergen County Central Tumor Registry contained 1,906 cases reported from January 1, 1962, to March 27, 1963. The pilot study of 854 cases from the Bergen Registry will be reported by June 1, 1963.

RECOMMENDATIONS

1. That the Special Committee on Cancer Control include in its activities promotion of an expanded cancer detection program that will include all practicing physicians.
2. That the special committee establish liaison with the Medical Advisory Committee of the New Jersey Division, American Cancer Society, to enlarge the scope of an educational program.

Approved (page 348)

CHILD HEALTH

Robert E. Jennings, M.D., Chairman, South Orange

(Reference Committee "G")

Two meetings of the Special Committee on Child Health were held during the year. In addition, a postal poll on three important questions was solicited, in lieu of a regular meeting.

On March 27, 1963, a "Symposium on School Health" was held at the Edgebrook, New Brunswick, New Jersey. This was undertaken as a joint meeting sponsored by The Medical Society of New Jersey in conjunction with the New Jersey State Departments of Health and Education. Dr. Donald Dukelow of the Department of Health and Education, American Medical Association, spoke on the "Real Role of the School Physician." Other talks on the role of the Medical Society in school health and on screening tests for vision and hearing were presented. The symposium was well attended by representatives of the medical, nursing, and school administrative groups.

The Board of Trustees endorsed the organization of the School Physicians of New Jersey under the Special Committee on Child Health. The organizational meeting will be held following the Pediatric-Surgical session of The Medical Society of New Jersey in Atlantic City on May 13, 1963.

At the request of The Medical Society of New Jersey, Governor Hughes proclaimed the first week of April 1963 as "Child Safety Week." Each component society was urged to cooperate in this project using the proceedings of the 1962 Child Safety Symposium as a guide to its activities. Public relations ma-

terials were supplied from the Executive Offices for the use of component societies. The counties of Middlesex and Essex have cooperated in attempting to set up a local Community Committee on Child Safety with gratifying results.

The Child Health Committee hopes to provide educational kits on Child Safety for promotion of the community efforts at the local level.

RECOMMENDATION

That The Medical Society of New Jersey continue its efforts to revise Section 18:14-17 of the Revised Statutes—Chapter 25 of the Laws of New Jersey of 1955—to enable the schools to accept evidence of a physical examination by the family physician in lieu of a mandatory examination by the school psysician.

Approved (page 348)

THE CHRONICALLY ILL AND THE AGING

Matthew E. Boylan, M.D., Chairman, Jersey City

(Reference Committee "G")

The Special Committee on the Chronically Ill and the Aging held three regular meetings throughout the year. There were two special meetings, one with the New Jersey Joint Council to Improve the Health Care of the Aged; a second was a joint meeting of this committee with the Special Committee on Rehabilitation. Attendance at all meetings and participation in the business at hand were exceptionally good.

Accreditation of nursing homes was one topic actively discussed and explored by the committee and was the reason for the meeting with the Joint Council to Improve the Health Care of the Aged. The opinion rendered was that the project of accreditation and certification of the nursing homes of New Jersey should be subject to further investigation and study. It was agreed that the committee urge affiliation of nursing homes with general hospitals.

A recommendation was adopted urging each component society to establish liaison with the local agencies responsible for planning and establishing housing projects for the aged.

It was further recommended to component societies that the members of their Committees on the Chronically Ill and the Aging offer themselves as liaison consultants to all golden age and senior citizens groups within their county boundaries.

HOME CARE PROGRAM

The following policies and principles of a Home Care Program as drafted by the committee were approved by the Council on Public Health and by the Board of Trustees:

Objectives

To provide certain extension services to patients in the home which would normally be provided in the hospital.

The Home Care Program should have the approval of the local county medical societies or their definitive committees.

Referrals

All referral of patients to the Home Care Program must initiate from the patient's own physician.

Amended to read: "All referral of patients to the Home Care Program must have the approval of a physician."

Personnel

The personnel of the Home Care Program will consist of a team under the direction and coordination of a medical doctor. The team will include the patient's own physician, the

coordinating physician (who should be a doctor of medicine), and other related personnel (such as a social worker, physical therapist, registered nurse, etc.).

Amended to read: "The personnel of the Home Care Program will consist of a team under the direction and supervision of a medical doctor. The team will include the patient's own physician, a coordinating officer, and other related personnel (such as a social worker, physical therapist, registered nurse, etc.)."

Evaluating the need of the patient is a job for the entire team.

Amended to read: "Evaluating the needs of a patient is a job for the entire team, but his medical care must continue to be the sole responsibility of the attending physician."

Cases to be Covered

There is to be flexibility in the selection of eligible participants in the Home Care Program—not merely chronic illnesses to be considered, but acute illnesses as well.

The responsibility for developing the procedures to implement and continue the Home Care Program is vested entirely in the coordinating team, and should provide the following:

1. Coordination by coordinating physician.

Amended to read: "Coordination by coordinating officer."

2. Services of home care team, such as the patient's physician, the coordinating physician, and other related personnel.

Amended to read: "Services of the home care team, such as the patient's physician, the coordinating officer, and other related personnel."

3. Homemakers services, when necessary.

4. Maintenance of medical records.

5. The program should make available the essential supplies and equipment necessary for the proper care of the patient.

6. Laboratory services.

7. Radiology services.

8. Transportation from the home to the hospital and return should be provided for any special services.

Adopted as amended (page 348)

In the joint meeting of this committee with the Special Committee on Rehabilitation as directed by the 1962 House of Delegates—to coordinate their efforts in the determination for the need of a directory of services—there was found to be a definite need for such. The joint meeting was advised that the State Society could not of itself undertake such a project. It was suggested that each component society be urged immediately to begin compilation of its own listing, if it has not already done so. Then the State Society could make available to all counties a compilation of these services pertinent to others outside the county of original listing.

On January 14, 1963, S-12 was signed into law, which will implement the Kerr-Mills Law in New Jersey. Incorporated in this law the Commissioner of Institutions and Agencies is empowered to appoint a qualified expert, who among other duties shall:

(a) conduct a continuing survey of facilities for health services, and maintain a roster of such facilities which are approved for utilization in carrying out such programs.

Perhaps a meeting with the new Commissioner, when appointed, will be effectual in the establishment of the needed directory.

The committee, on referral from the Legislative Council, considered two Legislative Bills, S-287 and S-288. The committee submitted to the Council on Legislation a recommendation that S-287 be approved and S-288 be disapproved.

The chairman wishes to acknowledge the splendid attendance of his committee throughout the year and to thank all the members of the committee for their cooperation and efforts.

CONSERVATION OF HEARING AND SPEECH

James H. Spillane, M.D., Chairman, Phillipsburg

(Reference Committee "G")

Your committee's exhibit on the detection and classification of hearing loss at last year's annual meeting was well received.

The committee has continued to follow the progress of speech and hearing centers throughout the State and has had numerous meetings with members of the New Jersey Chapter of the American Speech and Hearing Association. It is felt by the committee that a close relationship is being developed which should be of mutual benefit.

Study continues on a screening program for hearing defects. The committee has obtained from the county superintendents of schools outlines of the methods of screening being used in most counties in New Jersey. It has studied plans, some of which have been enacted into law, in other states.

The Division of Constructive Health of the State Department of Health is planning a pilot study in the school systems in four counties in the very near future. The Director has met with your committee. It would appear that his program should be an excellent one. We hope our suggestions were a contribution to this study.

The problem of the driver with impaired hearing has been studied. It is the opinion of your committee that no restrictions should be placed on him at this time.

Your committee dealt with many communications during the year, answering some directly and reporting others to the proper committees of the Society.

The committee noted that efforts continue to evolve some form of control of hearing aid dealers and salesmen.

It will also continue to oppose the establishment and operation of centers for the evaluation and care of patients with speech and hearing defects when these centers do not have adequate medical supervision.

Adopted (page 349)

CONSERVATION OF VISION

Samuel M. Diskan, M.D., Chairman, Atlantic City

(Reference Committee "G")

EYE BANKS

The Special Committee on the Conservation of Vision suggested studies to facilitate the donation of eyes to eye banks, and change the laws that now partially inhibit this program. A bill embodying these objectives was introduced in the New Jersey Legislature in March (1963). Its early passage is hoped for. A study was made of the Eye Banks in this area in an attempt to improve their effectiveness.

EYE HEALTH SCREENING PROGRAM

For the sixth consecutive year, The Medical Society of New Jersey, under the auspices of the Special Committee on Conservation of Vision, conducted a statewide Eye Health Screening Program. The program was aided and supported by the New Jersey Academy of Ophthalmology, the New Jersey State Commission for the Blind, and the New Jersey Hospital Association, but it could not have been possible without the invaluable assistance of the Executive Office Staff and the support of the Council on Public Relations.

The program was conducted in the last week of September 1962 and was manned by approximately 180 ophthalmologists; 7,756 persons were screened. This is 4.4 per cent more than during 1961 and the largest number ever tested under this program. Fifty per cent of those tested were found to need corrective eye care. This program is probably one of our better public relations and eye health projects and should be offered to the public next year with increasing efforts to expand the size of the program.

New Jersey physicians are urged to support this project and encourage their patients to attend the screening program scheduled in their area.

SCHOOL EYE HEALTH PROGRAM

A great deal of time was spent by the committee with the object of presenting a uniform Eye Health Program that could be effectively used in the schools of New Jersey. Meetings were held in conjunction with Mrs. Emma Howe, representing The New Jersey Commission For The Blind, and Doctor Geoffrey W. Esty, representing the New Jersey State Department of Education. The committee published a booklet "An Eye Health and Eye Screening Program for Schools," as the standard text for the development of this program. The booklet was distributed throughout the school systems. "Workshops" were held in various parts of the state for school administrators, nurses, and physicians.

CONTACT LENSES

The opinion of the Attorney General in regard to the contact lens question was somewhat contradictory, in that it pointed out that several procedures required for the correct practice of fitting contact lenses was proscribed to optometrists, yet it indicated that the law as written does not prohibit optometrists from prescribing contact lenses. The committee requested that the Society's legal counsel study this opinion. This matter is now in the hands of the Council on Legislation for further action.

OPTICIANS

The members of the committee have also been sensitive to the significance of a number of civil suits that have been instituted against opticians who were working in conjunction with ophthalmologists. The attention of the Society has been called to these suits to the end that the actions may be closely studied to be sure that they do not silently embody attempts to invade the area of lawful privilege accorded the fully licensed physician and surgeon of New Jersey.

RECOMMENDATIONS

1. That the House of Delegates approve the continuation of the Eye Health Screening Program, scheduled for the week of September 23, 1963.
2. That the School Eye Care Program be approved as presented for continued action by the committee next year.
3. That the committee, in the interest of the public welfare at large, continue to investigate the contact lens problems.

Approved (page 349)

MATERNAL AND INFANT WELFARE

John D. Preece, M.D., Chairman, Trenton

(Reference Committee "G")

The chief activities of the committee this year were in the usual collection and classification of maternal deaths. We were happy to receive a report from the New Jersey Department of Health that a new all-time low for maternal deaths had been reported for the year of 1961. The disturbing element of the report was that under the classification of sepsis eight deaths were reported, whereas this classification would have reported an all-time low of only one death for the year were it not for the inclusion of seven additional deaths due to septic abortion.

The committee recommended that this fact be drawn to the attention of the Society through an article in THE JOURNAL. This was approved by the Board of Trustees and such an article consisting of case reports will be published. To add emphasis, the Editor of THE JOURNAL will publish in the same issue an article on the treatment of septic abortion which was presented at the New Jersey division of the American College of Surgeons.

The committee looks forward to further publication of case reports which may contribute to the continued reduction of maternal deaths in the State of New Jersey in 1963.

Adopted (page 349)

MENTAL HEALTH

Robert S. Garber, M.D., Chairman, Belle Mead

(Reference Committee "G")

This has been an unusually active year for this committee due to the unprecedented stand of the American Medical Association through its Congress on Mental Illness and Health.

A fifteen member statewide steering committee—comprised of five persons from the Medical Society, five from the New Jersey District Branch of the American Psychiatric Association, and five from the New Jersey Association for Mental Health—was conspicuously represented in Chicago at the Congress in October 1962.

Following the Congress, the Mental Health Committee held a statewide meeting of county chairmen of Mental Health—at which meeting a majority of the counties were represented —and the following recommendations were adopted:

1. That county chairmen of mental health committees accept this discussion as a challenge; return to their county societies and arrange meetings and plan ways to stimulate interest and understanding on the part of non-psychiatric physicians in their counties.

2. That before May 1, 1963, county mental health chairmen meet with their local committees and organize a small Mental Health Congress within their county, to which would be invited representatives from other county committees, organizations of psychologists, social workers, registered nurses, public health nurses, occupational therapists, judges, county bar association, educational association, county school system, diagnostic teams, hospital administrators, community chest, family service, probation officers, state hospital volunteers, and such others as they might wish.

3. That each county committee appraise the services, coordinate and integrate information available from existing studies, and discuss problems and needs of their community and possible future plans.

4. That the chairmen of county mental health committees reconvene in Atlantic City during the annual meeting to digest reports from counties, and make such appropriate determinations as are necessary.

In recognition of number four above, a progress report on the results and actions of county congress meetings will be forwarded to the next administration.

In conclusion, this has been a gratifying year especially because of the considerable impetus given to the vast area of Mental Health provided through the utilization of the forces of the American Medical Association.

Adopted (page 349)

REHABILITATION

Elmer J. Elias, M.D., Chairman, Morristown

(Reference Committee "G")

Several meetings were held during the year to crystallize the thinking toward compilation of a Directory of Rehabilitation Facilities present in New Jersey. With each passing year the magnitude of the project has increased many fold, and it is quite evident our resources are insufficient to cope with the project.

A joint meeting was held with the Special Committee on the Chronically Ill and the Aging and a similar conclusion was established.

Finally, a meeting was held with the Commissioner of Health and the Acting Commissioner of Institutions and Agencies, and it was conclusively determined that by means of law (S-12, 1962) " a qualified expert shall be appointed who will conduct a continuing survey of facilities for health services and maintain a roster of such facilities which are approved for utilization in carrying out such program."

In light of this new development, no recommendations are offered at this time for action by the House of Delegates.

Adopted (page 349)

Special Committees • • •

DISASTER MEDICAL CARE

Jack R. Karel, M.D., Chairman, Hillside

(Reference Committee "H")

The Special Committee on Disaster Medical Care has had a very active year, both in trying to alert the physicians to their responsibilities in the Civil Defense effort in New Jersey and in maintaining constant liaison with the Medical Division of the New Jersey Department of Defense. During the Cuban Crisis in October 1962, the chairman, in his additional capacity as Medical Coordinator of the Union County Civil Defense and Disaster Control organization, received a teletype message alerting the civil defense personnel. This information was immediately given by telephone to the President, Doctor Wegryn, who instructed the chairman to keep him informed as well as the Executive Officer, Richard Nevin, with regard to any important developments. The chairman also maintained contact with the State Commissioner of Health and the Coordinator, Medical and Health Services of the Department of Defense.

Accomplishments of the committee were as follows:

1. First Aid equipment as a compulsory item on all school buses was updated by the elimination of items that were obsolete and the addition of newer equipment. These recommendations were supplied to the New Jersey Board of Education.

2. The recommendation that the Medical Self-Help Training Program be intergrated into the health program in all secondary schools of New Jersey was approved by the State Commissioner of Education. The Medical Society then forwarded this approval to 597 District Boards of Education and 21 County Superintendents of Schools. By this action, New Jersey took the leadership in this long range educational program.

3. The Diocesan Superintendents of the parochial schools in the State of New Jersey have been notified of the recommendation that the Medical Self-Help Training Program be integrated in the health education of all their secondary schools.

4. The committee prepared an article entitled—"Excerpts from the Basic Civil Defense Law as It Affects the Doctor"—which was published in the November 1962 issue of THE JOURNAL of The Medical Society of New Jersey. This article informed the members of existing civil defense laws and of their responsibilities under them.

5. The committee will have an educational exhibit at the 1963 Annual Meeting showing a model of a 200-Bed Civil Defense Emergency Hospital in operation. The Medical Self-Help Training Program will also be exhibited as a long range teaching program for secondary schools and for the general public.

Accepted (page 349)

NURSING EDUCATION

Irving M. Levitas, M.D., Westwood

(Reference Committee "H")

A resolution was passed by the House of Delegates of The Medical Society of New Jersey at its 1961 session to form a committee to study the problem of student nurse recruitment. The purpose of this committee was to attempt to inquire into some of the reasons for failure of increased enrollments in nursing schools and to bring together the various organizations that have an interest in the problem.

To illustrate the problem of the nurse shortage the following figures are of interest:

	1950	1955	1960
Number of Professional Nurse Schools	42	43	40
Number of Students in these Schools	2,691	3,000	3,290

The increase in hospital beds has outstripped the supply of nurses to staff them and the situation is gradually getting worse. The State Department of Labor and Industry has recently pointed out that nearly 1000 nurses annually will be needed to replace those who leave the profession, and as of now only enough nurses are being graduated by the nursing schools to satisfy replacement needs. This does not help in supplying nurses for the newer requirements that are necessary.

On the national level President Kennedy in 1961 authorized the Surgeon-General of the Public Health Service to establish a consultant group on nursing. It recently issued its report stating that by 1969 the country must have 75 per cent more graduates than in 1961 in order to supply the needs. It furthermore stated that federal aid was direly needed for school expansion, scholarships, and research into methods of education. The economic status of the nurse was also considered to be a discouraging influence in recruitment.

About the same time another committee consisting of members from the National League for Nursing and the Public Health Service announced plans to study ways and means to increase the capacity of present schools and to establish new facilities so as to increase nurse graduates.

The time is therefore at hand for the Medical Society of this State to help in meeting the challenge.

The organization meeting of the Special Committee on Nursing Education was held on November 15, 1961.

Statistics concerning the number of nursing schools and the number of nursing students were discussed. If the needs of the hospitals and public are to be met, more nurses must be educated. It was concluded that one way to do this is to encourage the formation of more two year schools both from existing three year diploma programs and from new schools to be established. While graduates from these programs might require further practical educational experience, this could be afforded in the hospitals by in-service training programs.

The committee felt that the Medical Society should encourage nurses in their attempt to improve salary levels, as this has an effect on recruitment of students. There was also a need to reclaim through refresher courses those women who have been away from nursing practice for a period of years because of family obligations. A large pool of such women exists and many can return to active work with brush-up training.

It was decided to meet with representatives from the State Nurses Association, the State Hospital Association, the State League for Nursing, principals of Nursing Schools, and officials from the State Department of Education.

A meeting was held with the representatives of the New Jersey State Nurses Association on December 20, 1961. It was pointed out that the Medical Society was offering its assistance with the purpose of stimulating nurse recruitment.

Discussion with the nurses indicated that they believed that two year programs are definitely feasible. They believed that higher salaries within the profession are necessary to attract a greater supply of students. It was suggested that working conditions in many hospitals were poor and that in some their grievances are not able to be heard. They said there were certain hospitals whose nurses were forbidden to belong to the State Nurses Association and that some nurses were discharged by the hospital administrators if they joined. They felt that in many institutions the professional nurse enjoyed little status, had little to do with determining hospital policy, and that their opinions were not considered. Because of these factors they felt they could not become enthusiastic and really strongly encourage nurse recruits. The association is of the opinion that the responsibility for nurse education is for nurses alone, but they would be happy to meet with allied professions and administrators to aid with educational planning.

A meeting was held with the representatives from the New Jersey Hospital Association on February 7, 1962. They had the following views:

They felt that two year diploma programs with supplemental in-service hospital training programs would be entirely satisfactory in helping to increase the supply of nurses. Administrators believe that the State Board of Nurses Examiners should be more broadly represented and possibly the Governor or Attorney General should be approached to discuss how nominees to the board are picked and length of tenure. They felt that the reason some hospitals had discontinued nursing schools or had not expanded them is because of lack of funds. More scholarship assistance is needed, and State or Federal funds will be

needed if the increased supply of nurses is to be accomplished. They believed that the community colleges should have two year programs. The discussion also led to the conclusion that credits in the diploma programs are not being awarded equitably by the colleges for those girls who want to use their nursing school training toward a degree. This discourages girls who feel their three years may be largely wasted if they wish eventually to get college degrees.

The administrators felt that the section of nursing school directors under the State Nursing Association was not as effective as it should be and that perhaps a different type of association—possibly independent of that organization—might be preferable.

They agreed that while starting salaries for nurses were not very attractive there are many supervisory positions open for ambitious girls which offer excellent salaries. Practical nurses do not really compete with registered nurses since their duties are not the same and the number of practical nurses used does not affect the rates of registered nurses per patient. The representatives indicated that a meeting of all organizations interested in nursing education should be productive and in fact is necessary in order to meet the serious shortage of nurses.

A meeting was held with fifty-three representatives from twenty-seven hospital diploma schools on April 4, 1962. Prior to this meeting, a forty-five item questionnaire had been sent out to the schools. Seventeen schools returned them and eighteen did not do so. The following are some of the pertinent findings taken from the returns:

Five school heads indicated they had never received any information about the experiment of the two year associate degree program which was concluded in New Jersey in 1957. In general they were satisfied with the State Board of Nursing, but had reservations about its ability to help the schools more and also about the length of time of appointments to the Board.

Nine schools felt that the two-year program would be feasible for their hospital. However, of nine hospitals that had experience with graduates of such programs only one found them completely satisfactory. But most felt that after six to twelve months of staff duty, the graduates were the equal of the three year diploma graduates.

Five schools had difficulty getting their quota of students, and six stated that even if demand for places increased they could not expand because of lack of funds. Six schools said money was needed for capital expansion, scholarship aid, and adequate instructors salaries, and ten felt that more funds would help increase the nurse supply. Ten believed that nurses' salaries are inadequate.

As to the recruiting, some indicated that guidance departments in the secondary schools tended to discourage students from going to hospital schools. Thirteen heads indicated that physicians have been of no help with their problems but felt they did have a part to play if they would accept it.

Eleven stated that not enough credit was given toward academic degrees, and ten thought maybe the State Department of Education might be helpful in this matter. Eight believed that the Community College Bill might be of value in student enrollment. Finally ten were hopeful about the future of the hospital program but six had their doubts.

The meeting on February 13, 1963, was held with representatives of the New Jersey League for Nursing and the State Department of Education. The following were some opinions from the League's representatives:

They thought that student enrollment may have increased in 1962 but figures were not yet available from the Board of Nursing Examiners. It was pointed out that the two year Associate Degree program and the Hospital Diploma program both prepare for the same jobs. The costs to the student of the former are higher but they earn money sooner. There are many sources of supply of nurses, they are the four year college degree, the two year associate degree, the three year diploma program, the still relatively unused two year hospital diploma program, and the schools for practical nurses. All have their place and are not competitive. The time has come to stop the debate on which method is best. The League is interested in using all of these educational methods to increase enrollments. It was pointed out that a great untapped source is the male student nurse. With improvement in wage scales, possibly more men can be attracted into the profession. There are many special uses for males in this work.

The representative from the State Department of Education indicated the following:

Physicians, Nurses, and Hospital Administrators should make their point of view known to the proper authorities in those counties where the Community Colleges are to be established as proper early planning is essential. Also five per cent of high school students are eligible for State Scholarships. These can be used by those going into nursing. There are also considerable amounts in various Federal funds which are at times unused. For example there are funds available in certain areas for job training. Thus some unemployed might be eligible for nurse training if the demand is sufficient and made known to Federal and State

officials. He also stated that for many years we have had State supported Teachers Colleges established because of the need for teachers. If there is enough public and professional demand there is no reason why the State cannot do the same for nurses. The Department of Education may be interested in this possibility.

All participants at the meeting felt that a permanent committee be formed to consist of members of the nursing schools (Degree, Associate Degree, and Diploma) the New Jersey State Nurses Association, the New Jersey Hospital Association, The Medical Society of New Jersey, and those necessary governmental agencies, so as to coordinate the efforts of all to meet the serious problem of the nurse shortage.

The following conclusions were made by this Special Committee on Nursing Education:

1. There is a need for more coordinated planning between the various organizations interested in nursing education as to how to increase enrollments. None of these above can solve the problem. A permanent group should be formed consisting of representatives from the State Medical Society, State Nurses Association, State Hospital Association, the State League for Nursing, administrators of nursing schools, and possibly advisers from the New Jersey State Department of Education.

2. Nursing schools do not have sufficient funds for expansion. Federal and State funds must be sought as private funds and Hill-Burton money are used essentially for hospital bed expansion. If this is so then State officials will have to be consulted as to how these funds may be made available.

Amended to read:

"Nursing schools do not have sufficient funds for expansion. It is obvious that there are public and private funds not fully utilized for the expansion of nursing education. Further investigation and use of these funds are recommended." (page 350)

3. The Medical Society should take a more active interest in this matter. Members should serve on nursing school committees. Possibly each component society should have a committee on nurse recruitment to help in public relations, to establish liaison with Freeholders in those counties where Community Colleges are to be established and as individuals to encourage girls to enter the nursing profession. At the present time 5.3 per cent of high school graduates are entering the field. If 6 per cent would do so the necessary number would be obtained. If one doctor in three could be responsible for getting one girl into training New Jersey would have 2250 more students per year.

4. The committee feels that this special committee should now cease to function and another committee be formed so the purpose of paragraph #1 above can be accomplished.

RECOMMENDATIONS

1. That this report be sent to all the organizations and administrators that participated in these conferences so the viewpoints of all can be known.

Approved (page 350)

2. That The Medical Society of New Jersey ask all interested groups to form a committee to deal with this problem. This group can then coordinate its efforts with the necessary public officials to help speed up the solution.

Approved (page 350)

3. That The Medical Society of New Jersey petition the Governor to hold a special conference on nurse recruitment, utilizing the above groups and adding the necessary public officials so planning may be translated into action.

Approved (page 350)

Report approved as amended. Recommendation of the reference committee adopted that a permanent Committee on Nursing Education and Recruitment be established. (page 349)

PHYSICIANS PLACEMENT SERVICE

Samuel J. Lloyd, M.D., Chairman, Trenton

(Reference Committee "H")

The Special Committee on Physicians Placement Service met on March 3, 1963 to review and evaluate the effectiveness of the existing procedures used to administer the Physicians Placement Service.

In the light of the fact that during the current administrative year only one physician was definitely known to have been placed in New Jersey as a direct result of the efforts of the Physicians Placement Service, the committee discussed whether or not the end result justified the expense to the Society in terms of the time-consuming clerical work involved. The results of a placement questionnaire distributed to the other state medical societies by the Physicians Placement Service indicated that, in general, other state societies likewise do not know the effectiveness of their placement activities.

The following facts were brought out in the committee's discussion:

1. The majority of requests from physicians seeking location in New Jersey come through the AMA. These physicians appear on multiple listings, since most of them express a desire for the Eastern coast rather than New Jersey exclusively. Some are available for placement anywhere in the United States.

2. The physicians seeking location are predominantly specialists, with only a minimal number interested in placement as general practitioners.

3. Practically all community areas currently seeking physicians request general practitioners; for some, listings have been carried for years.

4. Thus far its has been the opinion of physicians who have investigated the New Jersey community opportunities listed with the Service that none of the communities applying are in position to support a physician.

Since Physicians Placement Service is offered as a benefit of membership, the committee discussed the desirability and feasibility of permitting members who are seeking associates, and of communities whose county medical societies confirm their need for a physician, to advertise through THE JOURNAL in lieu of quarterly report forms.

The committee in its report to the Board of Trustees recommended that:

1. Members of MSNJ who are seeking associates be permitted to list this information in the classified section of THE JOURNAL, free of charge, for a maximum of three months, under uniform terms established by the Physicians Placement Committee in consultation with the Publication Committee.

2. A similar opportunity should be afforded to communities seeking physicians, if the need of such communities has been verified by the component medical societies in their areas.

The Board of Trustees, meeting on March 17, 1963, adopted recommendation number one, but took no action on recommendation number two.

The Board of Trustees, after discussing the availability of other channels for placement—such as the classified advertisements in *The Journal of the American Medical Association* and listings in, and contact with, local hospitals and their staffs—and considering the limited benefits realized by the Physicians Placement Service as operated, unanimously agreed that the work and cost involved did not warrant the continuance of the Service and its sponsoring committee, and directed that the Service be discontinued and the committee disbanded at the end of the current administrative year.

Approved (page 350)

RETIREMENT PLAN FOR PHYSICIANS

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "D")

The Special Committee on Retirement Plan for Physicians has worked with renewed interest and activity because of the passage of the Keogh Bill in October, 1962. Under this new law, self-employed persons are given a limited income tax deduction for amounts set aside to fund future retirement benefits under an employee's retirement plan that qualifies for tax exemption. By now, we assume that all physician-members of this society are acquainted with the highlights of the Keogh Law such as eligibility of the participants; *i.e.*, physician-employers, their employees, etc., the limits of amounts eligible to be contributed—both deductible and voluntary non-deductible—and, finally, permissible investment methods.

A retirement plan could take the form of a pension trust, custodial account, an annuity program (including non-transferable face amount certificates), a profit-sharing or stock bonus plan, or a plan which purchases a special U.S. bond authorized in the law.

This has again raised the question: "Can we as a Society offer our membership a plan whereby as a group association we could pool our investments and secure savings in administrative costs and management and consequently greater capital gain than each member can obtain acting as a single individual?"

This committee has considered various plans among which were:

1. An annuity plan type of investment offered by E. & W. Blanksteen Agency of Jersey City through the Banker's Life of Iowa.

2. An equity plan submitted by Standard & Poor's Corporation of New York involving a self-administered diversified open-end investment company sponsored by the society with the bank as custodian and the society to furnish the mutual fund officers who would have the responsibility of managing investments of the individual members. (An example of this is the Beacon Investment Corporation of New England sponsored by the New England States Medical Societies.)

3. The Scudder-Stevens-Clark and Banker's National Life proposal, a plan which enables the members to put their money in a balanced investment fund consisting of guaranteed and variable dollars. The administrative work would be handled by a custodian bank which would receive the member's contribution and send half to Scudder-Stevens-Clark, common stock mutual fund, to buy shares, and the other half of the contribution to Banker's National Life Insurance Company of Montclair, New Jersey, to buy guaranteed cost life insurance policies. This plan would have licensed National Association Securities dealers to sell and service the plan.

4. Proposal by Bache & Company of New York City, offering a model plan with all permissible investment options included; *i.e.*, Government bonds, life insurance and annuities, using a reputable insurance company for the insurance option, a selected equity portfolio managed by Calvin Bullock, Ltd., and a split-fund investment combining insurance and annuities, and equities in balanced proportion to each individual's need. This involves the establishment by the society of a group trust using a bank of the society's choosing to act as Trustee to administer the Plan. In addition, the pooled resources and offices of Bache & Company, Calvin Bullock, Ltd., and the representative insurance company would be available, and they would furnish a staff of ten highly-trained investment specialists who would hold meetings with physicians and their personal attorneys, etc., to formulate individualized plans where necessary.

Other plans, too numerous to mention, were submitted and considered but essentially the above outlined plans were representative of what is currently available. The chairman of this committee will make available to any member, any of the literature in his possession which could supply more detailed information on the above.

As presently set up, the Keogh Act is filled with loopholes, hazards and traps, and until the Internal Revenue Bureau issues its regulations, no plan can guarantee that it will qualify under the Keogh Act. Despite all the disappointing features, however, this new law opens an important door, and it can be assumed that the benefits of the Keogh Act could well be extended and expanded as years go by. Therefore, this committee feels that doctors should start making plans to take ad-

vantage of the Keogh Act for the benefit of themselves and their employees as they see fit. Another thought, not to be lost sight of, is that the Keogh Plan is in effect a forced saving plan. We therefore feel that this committee should be empowered to continue to investigate actively all possible avenues of programmed retirement plans at local and state level, and to attempt to draw up a model plan for the society membership acting as a group as soon as the Internal Revenue regulations are published. Any plan this committee will offer will endeavor to represent the soundest investment counseling obtainable, with built-in individualized features suitable to all members of this society.

The committee advises, moreover, that individual physicians presently do not commit themselves to any specified plans until all the Internal Revenue regulations are published.

At this time the watchword of the Special Committee on Retirement Plan for Physicians is—*Proceed with Caution*—but plan ahead.

RECOMMENDATION

That the Special Committee on Retirement Plan for Physicians be empowered to continue to investigate actively all possible avenues of programmed retirement plans at local and state level and to attempt to draw up a model plan for the society membership acting as a group as soon after publication of the Internal Revenue regulations as possible.

Approved (page 341)

TRAFFIC SAFETY

William L. Sprout, M.D., Chairman, Salem

(Reference Committee "H")

The Special Committee on Traffic Safety has through the year concerned itself with the accident-prone person, the Governor's Conference on Traffic Safety, the problem of glare recovery in night driving, re-examination of licensed drivers, and seat belts as a safety factor.

The committee has continued to make itself available for consultation with the Division of Motor Vehicles. By action of the Board of Trustees, a special advisory panel was appointed to assist the Director of the Division in determining whether individuals reported as suffering from incapacitating cardiac conditions may safely be granted licenses to drive. The committee has supported a program of adequate eye-screening as basic for the dependable re-evaluation of drivers of advancing age.

The committee has supported the Board of Trustees in its recommendations as to reliable uniform criteria to be utilized in deciding whether a driver is under the influence of alcohol. The Society has recorded itself, by action of the Board of Trustees, as supporting the recommendation of the AMA House of Delegates, adopted at the 1962 clinical meeting in Los Angeles, namely:

1. That the reporting of alcohol concentration in the blood be based on milligrams of alcohol per 100 milliliters of blood and

2. That the concentration of 100 milligrams per 100 milliliters be accepted as prima facie evidence that the person tested is under the influence of alcohol.

The Society has approved a bill (S-35 . . . Waddington) to require all passenger cars manufactured after July 1, 1964, and registered in this State, to be equipped with at least two sets of safety belts for the front seat. This measure is still in Senate Committee.

Accepted (page 350)

Resolutions

1

STATE-WIDE MEDICAL EXAMINERS' SYSTEM

From the Burlington County Medical Society

(Reference Committee "E")

Whereas, the matter of County Coroners' investigations and autopsies in various localities throughout the State of New Jersey has been, for some time, a matter of concern to the public, to the authorities, and to the medical profession; and

Whereas, upon preliminary investigation certain glaring deficiencies have been found in the now archaic System of Coroners as they now function; and

Whereas, it would be beyond the means of individual counties to correct such deficiencies because of economic and other considerations; and

Whereas, it is believed that the problem can best be resolved by a State-Wide Medical Examiners' System which would require public support and new State Legislation, and considering that it is a function of organized medicine to advise and provide leadership in matters of public interest in which they are involved; now therefore be it,

Resolved, (1) That The Medical Society of New Jersey go on record in favor of a change from the present County Coroners' System to that of a unified, efficient, and complete State-Wide System of Medical Examiners; and

(2) That this resolution with suitable explanations and comments be made known to the public through the press and to the various governing and legislative bodies, individuals, and agencies that may be instrumental in accomplishing the purpose of this resolution; and

(3) That a permanent Committee of The Medical Society of New Jersey be formed to pursue this matter in the future.

(Note of information: Commissioner Kandle, New Jersey State Department of Health, has advised that he "would entertain a request to assist The Medical Society of New Jersey or other State-wide medical group in a study of this complex problem.")

Approved (page 342)

2

AMA INTERN APPROVAL PROGRAM

From the Bergen County Medical Society

(Reference Committee "D")

Whereas, the Council on Medical Education of the AMA has proposed that the internship program of a hospital be subject to disapproval if the proportion of its house staff comprised of graduates of approved U.S. and Canadian schools falls below 25 per cent for two successive years, and

Whereas, such disapproval would in no way be based on lack of competence of the attending or house staff, on inadequate standards of professional care, or on an unsatisfactory graduate training program, and

Whereas, there are not a sufficient number of graduates of approved American and Canadian medical schools to fill existing approved internships and, as a result of the matching plan, few of these apply to voluntary hospitals for internships, thus making this criterion impossible for many excellent but small hospitals to meet, and

Whereas, the implementation of the proposed change could result in the withdrawal of approval for intern training in many of the hospitals in New Jersey currently so approved, and

Whereas, such action would create an even greater shortage of competent candidates for the house staffs of these hospitals, in which a substantial portion of the population receives medical care, and would therefore be detrimental to the public interest, and

Whereas, the proposed change would not contribute to improved standards in ANY hospital, now therefore be it

Resolved, that the Bergen County Medical Society disapproves of the proposed change in requirements for approved internship programs, and be it further

Resolved, that this resolution be submitted to the House of Delegates of The Medical Society of New Jersey for its action and transmission to the House of Delegates of the AMA so that appropriate action may be taken to rescind the adopted change.

Approved. Intent and resolved to be incorporated into one or more resolutions, as noted for Resolution #10. (page 340)

3

AMA INTERN APPROVAL PROGRAM

From the Morris County Medical Society

(Reference Committee "D")

Recognizing a clear and imminent danger further threatening already gravely harassed intern procurement by community hospitals implicit in the action of the AMA House of Delegates in November 1962, whereby failure to maintain a House Staff level at least 25 per cent graduates of accredited U.S. or Canadian Medical Schools might "warrant serious consideration . . . to disapproving the internship," and

Further recognizing that this problem particularly affects New Jersey hospitals inasmuch as 41 per cent of all foreign medical students on duty in the nation are located in the Middle Atlantic States of New Jersey, New York, and Pennsylvania, and

Because the above action fails to recognize the superior quality of many foreign trained interns, all ECMFG qualified, and in many cases, more able and better qualified than available graduates of U.S. and Canadian Medical Schools, and

Viewing with alarm that of 446 positions in the 41 hospitals of New Jersey, only 256 positions have been filled, 61 per cent of these by foreign medical graduates and foreseeing the certain increased difficulty in staffing without internship approval and the resultant tragic loss of services provided at a high level by community hospitals throughout this State; therefore, be it

Resolved, by this Medical Society that the resolution of the AMA House of Delegates will defeat the purpose of improving quality of patient care and intern education and, through appropriate channels, the rescinding of this action should be urged.

Approved. Intent and resolved to be incorporated into one or more resolutions as noted for Resolution #10. (page 340)

4

ROTATING INTERNSHIP IN THE COMMUNITY HOSPITAL

From the Morris County Medical Society

(Reference Committee "D")

Most of our citizenry who require hospitalization are treated today and will be treated in the foreseeable future in our community hospitals. It follows then that our doctors who are practicing medicine in these hospitals should be community-hospital-oriented.

It is proposed that this would be best accomplished by having every graduate physician serve a one year rotating internship in such a hospital. No hospital directly associated with a medical school could qualify for such an internship. However, this year of internship should be credited toward a residency requirement if the individual wishes to proceed into a residency, irrespective of specialty. Therefore, be it

Resolved, that the above proposal be adopted by the Morris County Medical Society and a copy sent to each county society and to The Medical Society of New Jersey; and be it further

Resolved, that it is requested of The Medical Society of New Jersey that this resolution be placed before the House of Delegates for its consideration, and gaining its approval it is suggested that it be forwarded to the AMA.

Disapproved. Intent has already been expressed to a degree in the resolution that has been adopted by the AMA House of Delegates. And Resolution #4 could produce a restriction on an individual in the pursuit of his hospital training after finishing medical school. (page 341)

5
UNION FAMILY HEALTH GROUPS
From the Bergen County Medical Society

(Reference Committee "F")

Whereas, the Bergen County Medical Society is dedicated to the best quality of medical care, which we believe is predicated on a personal physician-patient relationship; and

Whereas, Union family health groups have recently been organized by unions, industries, hospitals, and other non-medical groups for the practice of medicine, and

Whereas, this Society does not recognize the competence of labor unions to involve the practice of medicine in its bargaining negotiations with industry and hospitals, and

Whereas, these union groups through restrictive medical panels include only a small portion of the licensed physicians in their areas, thus depriving many patients of their right of free choice of physicians; and

Whereas, these union-controlled family health groups are in the active practice of medicine through the hiring of physicians on an annual basis, as well as requiring these physicians to staff the affected hospitals in addition to their union practice; and

Whereas, these groups threaten to affect adversely the present form of medical practice by making medical care impersonal, routine, and mass-produced; therefore be it

Resolved, that the Bergen County Medical Society opposes any form of medical practice which is not conducted and directed by physicians; and be it further

Resolved, that the Bergen County Medical Society hereby advises its members of the dangers inherent in all programs of such nature; and be it further

Resolved, that the Bergen County Medical Society asks its members who are alumni of any of the hospitals or medical schools which are cooperating or planning to cooperate with these union groups to notify their hospital and/or medical school of each alumnus' disapproval of such action; and be it further

Resolved, that the Bergen County Medical Society stands ready and willing at all times to discuss with hospitals, management, labor, government, or any other interested party, any plan for genuinely improving the present form of distribution of health services in our community; and be it further

Resolved, that copies of this resolution be forwarded to the Board of Trustees of The Medical Society of New Jersey, and to the county medical societies of New Jersey, New York City, Westchester, and Long Island, for their information; and be it finally

Resolved, that the delegates of the Bergen County Medical Society present this resolution to the House of Delegates of The Medical Society of New Jersey at its next meeting for the purpose of effectively implementing this resolution.

Recommendations of reference committee adopted:

(1) That the resolution be adopted.
(2) That a copy of the resolution be forwarded to the Council on Legislation so that it may be alerted to the problem.
(3) That a copy of the resolution be forwarded to each Hospital Medical Staff in New Jersey so that they may also be alerted to the presence of this situation.

(page 344)

6

JEMPAC

From the Bergen County Medical Society

(Reference Committee "E")

Whereas, upon request of the Board of Trustees of The Medical Society of New Jersey there was recently formed the New Jersey Medical Political Action Committee (JEMPAC), and

Whereas, JEMPAC is a non-profit, nonpartisan, and non-sectarian organization having as its purpose the stimulating of physicians, their wives, and others to a greater interest and a more active role in the elections of persons to public office who favor free enterprise and who will stand with organized medicine on matters affecting the health and general welfare of the public; therefore be it

Resolved, that the Bergen County Medical Society endorses the action of the Board of Trustees of The Medical Society of New Jersey by commending and supporting the efforts and leadership of the New Jersey Medical Political Action Committee; and be it further

Resolved, that the delegates of the Bergen County Medical Society be urged to introduce copies of this resolution to the May 1963 Annual Meeting of The Medical Society of New Jersey.

Adopted (page 342)

7

DEDUCTIBLE BLUE CROSS INSURANCE

From the Mercer County Medical Society

(Reference Committee "C")

Whereas, the Hospital Service Plan of New Jersey and other insurance companies have made it possible for many citizens of New Jersey to utilize the facilities of our hospitals and in so doing have permitted patients to reap the benefits of more and better medical care, and

Whereas, the facility with which hospitalization is now obtained due to insurance coverage has caused the hospitals to become overcrowded and on many occasions patients are admitted for other than purposes payable by Blue Cross, and

Whereas, the admission of the patient for other reasons than covered by Blue Cross has, at times, prevented the hospitalization of urgent cases, and

Whereas, deductible insurance, in which the subscriber pays a small portion of the bill before the full implementation of the provisions of Blue Cross attend, would discourage unnecessary utilization of hospital beds, and

Whereas, deductible insurance would bring about the reduction of insurance premiums, making Blue Cross available to a greater number of New Jersey residents, and

Whereas, the Hospital Service Plan of New Jersey sells a modified plan of insurance which fulfills in many respects the requirements of this resolution; therefore, be it

Resolved, that the Mercer County Component Medical Society go on record as supporting the principle of deductible Blue Cross insurance in which the subscriber pays a small portion of his hospital bill; and be it further

Resolved, that this resolution be presented for appropriate action to the House of Delegates of The Medical Society of New Jersey recommending that the Hospital Service Plan of New Jersey investigate and if possible implement this recommendation and gradually abandon the comprehensive plan and eventually offer only a modified plan in accordance with this resolution.

Not adopted. Realizing the importance of continuing study and investigation of utilization of hospital beds, this particular matter referred to the Board of Trustees of MSNJ for further action. (page 339)

8
ACCREDITATION OF HOSPITALS FOR THE CHRONICALLY ILL AND LONG-TERM PATIENT
From the Hudson County Medical Society

(Reference Committee "D")

Whereas, there are no standards of accreditation for hospitals for the chronically ill and long-term patient, and

Whereas, the Joint Commission on Accreditation of Hospitals had crystallized a program to establish such criteria and standards, and

Whereas, the American Medical Association was the moving force to have such a program tabled indefinitely, and

Whereas, the three other members of the Joint Commission on Accreditation of Hospitals—American Hospital Association, American College of Surgeons, and American College of Physicians—supported such a program, and

Whereas, voluntary hospitals, non-profit hospitals for the long-term patient, are a potent weapon against medicare and other such proposals; therefore be it

Resolved, that the Hudson County Medical Society record its objection to the AMA action; and be it further

Resolved, that a copy of this resolution be forwarded to the House of Delegates of The Medical Society of New Jersey for action at its May 1963 meeting, and, upon its adoption by the House of Delegates, be forwarded to the House of Delegates of the American Medical Association.

Referred to Board of Trustees of MSNJ for verification of the facts the resolution presents, as well as to determine what reasons the AMA may have had for withdrawing its support. (page 341)

9
REPORTING OF EPILEPSY BY PHYSICIANS
From the Monmouth County Medical Society

(Reference Committee "E")

Whereas, epilepsy is a condition the exact definition of which is often nebulous and controversial, and

Whereas, from the single viewpoint of motor vehicle operation it is merely one of many states in which a circumstantially hazardous alteration of consciousness may occur, and

Whereas, the patient himself knows as well as any what he experiences and what, as a matter of conscience, his civic responsibility must be, and

Whereas, it is simple and just to require anyone—under whatever sanctions the civil authority may impose—to divulge his physical qualifications to drive, according to his own reasonable knowledge, and

Whereas, the present law thus unjustly imposes upon a particular individual physician-citizen the obligation and responsibility of another, simultaneously appointing him against his will an agent of civil government, and

Whereas, it compounds injustice by placing, again against his will, the physician-citizen in multiple jeopardy, since he then becomes on the one hand vulnerable to a charge of legal violation and malpractice by failing to report, and on the other is liable for the legal defense of his diagnosis in the litigation which may follow dispute of his judgment when he has so reported, and

Whereas, further, the existing legislation forces the physician-citizen to assert and back with his economic and professional life the intellectually impossible, that is, the categorization as fact of that which may be justly classifiable as opinion or presumption, and

Whereas, finally, this continuing, antiquated, unworkable ordinance forces the physician to a course calculated to destroy the relationship with his patient on which both depend—the one for proper aid properly sought, the other for the fulfillment of the very purpose of professional existence; therefore be it

Resolved, That The Medical Society of New Jersey oppose, condemn, and urge the repeal of the New Jersey Law, R.S. 26:5-1, requiring the reporting of epilepsy by physicians; and be it further

Resolved, That The Medical Society of New Jersey inform the New Jersey State Legislature to this effect.

Approved (page 342)

10

ACCEPTANCE OF QUALIFIED GRADUATES OF FOREIGN MEDICAL SCHOOLS FOR HOUSE STAFF TRAINING PROGRAMS

From the Board of Trustees

(Reference Committee "D")

Whereas, acting upon supplementary report D of the Council on Medical Education and Hospitals, the House of Delegates—meeting in Los Angeles in November, 1962—adopted the following statement:

In order to maintain high standards of education and better assure the patients' welfare, at least 25 per cent of the total house staff (interns and residents) of a hospital should be graduates of accredited United States or Canadian medical schools. When United States and Canadian graduates represent a lesser portion of the house staff for two successive years, this will warrant that serious consideration be given to disapproving the internship; and

Whereas, previously the standards for granting approval to a house staff training program had been exclusively concerned with the educational qualifications of the candidates and with the educational quality of the training program offered; and

Whereas, previously candidates qualified themselves as acceptable either as graduates of an approved American or Canadian medical school or as graduates of a foreign medical school who have successfully passed the examination given by the Educational Council for Foreign Medical Graduates; and

Whereas, by its action the House added a new standard for determining the acceptability of a candidate for admission to an approved program, a standard utterly unrelated to his educational competence—namely, consideration of the geographical area in which the candidate pursued the studies leading to his M.D. degree; and

Whereas, by its action the House would deny to graduates of foreign medical schools who fully satisfy all proper educational requirments the opportunity to serve as interns in any hospital already having 75 per cent of qualified graduates of foreign schools on its house staff roster by threatening to disaccredit such hospital if it grants further acceptances; and

Whereas, such denial of the candidate's right to a place on the House Staff merely because of his geographical backgrounds would be indefensibly discriminatory, and would contravene the obligation of the medical profession of the United States—as the Council on Medical Education and Hospitals in its report so eloquently points out—" . . . to play a key role in furthering one of the objectives of the Exchange-Visitor Program . . . to increase mutual understanding between the people of the United States and the people of other countries"; and

Whereas, such denial would manifestly do a deep disservice to the fair name of American Medicine and to our country's international relations; now therefore be it

Resolved, that the House of Delegates of the American Medical Association rescind that action taken in Los Angeles and re-establish educational and qualitative standards as the exclusive criteria governing the operation of, and admission to, approved intern and resident training programs in all hospitals, affiliated or non-affiliated, in the United States.

Accepted and referred to the Board of Trustees to encompass the intent of this resolution along with resolution #2 and resolution #3 into one or more resolutions that will be concise, brief, and effective for presentation to the House of Delegates of the AMA at the June 1963 meeting. The intent of these is:

Resolved, that the House of Delegates of the American Medical Association rescind that action taken in Los Angeles and re-establish educational and qualitative standards as the exclusive criteria governing the operation of, and admission to, approved intern and resident training programs in all hospitals, affiliated or non-affiliated, in the United States. **(page 340)**

11

PERCENTAGE OF FOREIGN GRADUATES IN APPROVED INTERN AND RESIDENT TRAINING PROGRAMS

From the Board of Trustees

(Reference Committee "D")

Whereas, in supplementary report D—submitted by the Council on Medical Education and Hospitals to the House of Delegates at the Los Angeles meeting, in November 1962—the Council declared:

> It is noted with particular concern that some hospitals with full rosters of graduates of North American medical schools fail to accept reasonable complements of well-qualified foreign graduates into their internship programs annually. If our obligations are to be met, it is important that these hospitals provide opportunities for an adequate proportion of such graduates; and

Whereas, as the Council also declared in that report, it is the heavy obligation of the medical profession of the United States in furtherance of one of the objectives of the Exchange-Visitor Program . . . "to increase mutual understanding between the people of the United States and the people of other countries"; and

Whereas, the failure of certain hospitals to accept "reasonable complements of well-qualified foreign graduates into their internship programs annually" is in basic disregard of this heavy obligation of the medical profession and is destructive of the cited objective of the Exchange-Visitor Program; now therefore be it

Resolved, that this House adopt the following as its official policy:

> When United States and Canadian graduates represent a greater proportion than 75 per cent of the house staff of any hospital for two successive years, this will warrant that serious consideration be given to disapproving the internship and/or resident training program of every such hospital.

Disapproved. Best interest of improving our relationships with the medical schools and their graduates would not be served by this resolution. (page 340)

12

REPORTING OF COMMUNICABLE DISEASES

From Theodore R. Robie, M.D., Delegate from Essex County

(Reference Committee "E")

Whereas, the State of New Jersey Sanitary Code lists Epilepsy, Cerebral Palsy, and Mental Deficiency as communicable diseases and therefore reportable diseases, and

Whereas, this is inconsistent with modern medical knowledge in these respective fields, and

Whereas, it has been determined that grave disadvantages to sick persons, to the medical profession, and to the State Division of Motor Vehicles exist by retaining these three diseases on the reportable list, and

Whereas, a massive medical committee studied this question in detail and recommended that these three diseases be removed from the reportable disease list, and

Whereas, none of the three diseases—Epilepsy, Cerebral Palsy, or Mental Deficiency—are communicable diseases; therefore be it

Resolved, that The Medical Society of New Jersey recommend that the three categories of disease, namely Epilepsy, Cerebral Palsy, and Mental Deficiency, be stricken from the State of New Jersey Sanitary Code as reportable diseases; and be it further

Resolved, that the other reportable diseases listed be scrutinized with a view to bringing the list of reportable diseases in line with modern medical knowledge.

Amended to read:

Resolved, that The Medical Society of New Jersey recommend that the three categories of diseases, namely epilepsy, cerebral palsy, and mental deficiency, be stricken as reportable diseases, and be it further

Resolved, that the other reportable diseases listed be scrutinized with a view to bring the list of reportable diseases in line with modern medical knowledge.

Adopted as amended. (page 342)

13

TUBERCULOSIS CONTROL

From S. William Kalb, M.D., Delegate from Essex County

(Reference Committee "E")

Whereas, tuberculosis continues to be a major cause of serious illness for many of our patients despite the changes in its management that have transformed it from a legal into a chronic disease, and

Whereas, tuberculosis can now be eradicated, and

Whereas, New Jersey is far from this goal, and

Whereas, the nature of the tuberculosis control effort has changed, and it must change further as we progress to eradication, and

Whereas, the New Jersey State Department of Health, the New Jersey State Department of Institutions and Agencies, and the New Jersey Tuberculosis and Health Association requested Dr. J. Burns Amberson to form an expert committee to consider Tuberculosis Control in New Jersey, and

Whereas, the Amberson Committee has made specific recommendations, including changes in inter-governmental relationships, and

Whereas, the relationships of the efforts by the State, the Counties, and the Municipalities were set up two generations ago, and

Whereas, the members of our Society will be making a major effort in the eradication of tuberculosis and want efficient and effective support from hospitals and public health organizations; therefore be it

Resolved, that The Medical Society of New Jersey study the current situation in the attack on tuberculosis, and in particular the recommendations of the Amberson Committee, and the role the State should now play in the financing and coordination of local efforts against tuberculosis; and be it further

Resolved, that the appropriate committee of The Medical Society of New Jersey be directed to consider and report to the Board of Trustees on these matters by October 1, 1963.

Adopted (page 343)

14

MEMBERSHIP DIRECTORY

From George Heller, M.D., Delegate from Bergen County

(Reference Committee "A")

Whereas, each *Membership Directory* is a publication of ephemeral rather than of permanent value to the great majority of our membership, and

Whereas, hard and continued usage is the exception rather than the rule, and

Whereas, medical organizations of prestige are served adequately with rosters bound in less pretentious manner, and by following this procedure our Society may effect a saving of well over three thousand dollars on each publishing occasion; therefore be it

Resolved, that our Finance and Budget Committee instruct such individuals or committees responsible for the publication of the Directory to economize in this manner in the future.

Adopted (page 337)

15

RESPONSIBILITY OF AMA DELEGATES

From George Heller, M.D., Delegate from Bergen County

(Reference Committee "A")

Whereas, over the years the membership of our Society has never been informed in detail as to the activities of our delegates at the meeting of the AMA, and

Whereas, delegates' activities constitute the sole reason for boasting that the AMA is truly a democratic organization, and

Whereas, at meetings in recent years no zeal has been shown by certain delegates in pursuing the objectives of the membership in matters of declared wishes of the doctors of our state; therefore be it

Resolved, that each delegate to the AMA be instructed to acquaint himself with declared objectives, do what is in his power to carry out our wishes and render a report after each meeting to our Board of Trustees, this to be published for the information of the members of our Society.

Disapproved. Suggested that some further implementation of the present method of reporting by the AMA delegates be considered. (page 337)

16

PROPOSED GUIDES FOR PHYSICIAN-HOSPITAL RELATIONSHIPS IN NEW JERSEY

From Edward M. Coe, M.D., Delegate from Union County

(Reference Committee "F")

Resolved, that the draft of the Proposed Guides for Physician-Hospital Relationships in New Jersey, prepared by the subcommittee of the Council on Medical Services (mentioned in the printed report of the council, page 298), be referred to the appropriate reference committee for consideration.

Recommendations of reference committee, concerning the resolution and the Guides to Physician-Hospital Relationships in New Jersey, adopted:

(1) That the subcommittee continue its excellent and time consuming work with the Guides to Physician-Hospital Relationships, and that the committee contact the New Jersey Hospital Association at its earliest convenience to discuss these Guides.

(2) That every member of The Medical Society of New Jersey be circulated with a copy of the "Guides" in their present form so that they may acquaint themselves with the contents in order to make pertinent comments and suggestions to the subcommittee.

(3) That the subcommittee prepare as soon as possible a final version of the Guides to be presented to the Board of Trustees of The Medical Society of New Jersey for study and review prior to consideration by a subsequent House of Delegates meeting.

(page 344)

17

OPHTHALMIC TECHNICIANS

From Albert F. Moriconi, M.D., Delegate from Mercer County

(Reference Committee "E")

Whereas, the State Board of Optometry of New Jersey has instituted suit against an optician serving as a technician in the private practice of an ophthalmologist; and

Whereas, it is and has been the traditional right of a physician to utilize the services of technicians to assist him in the proper practice of medicine; and

Whereas, the action of the State Board of Optometry constitutes a serious attempt to curtail and restrict the right of the physician to practice medicine in New Jersey; and

Whereas, this attempt is of immediate concern not only to ophthalmology but to every physician regardless of his type of practice; now therefore be it

Resolved, that The Medical Society of New Jersey take whatever measures are necessary to combat this attempt to curtail and restrict the traditional right of physicians to utilize the services of assistants as they see fit for the proper practice of medicine in New Jersey.

Approved in Principle. Pointed out that, at present, opticians by law are not considered eligible assistants to physicians; that amending legislation is now being considered by the Legislature; that S-138 has passed the Senate and is expected to be presented to the Assembly soon. (page 343)

18

RETIREMENT PLAN FOR PHYSICIANS

From Albert F. Moriconi, M.D., Delegate from Mercer County

(Reference Committee "D")

Whereas, the Committee on Retirement Plan for Physicians of The Medical Society of New Jersey has studied many plans for the implementation of HR-10 (Keogh Bill), and

Whereas, in its annual report it has indicated the benefits available to the physicians by setting up a retirement program on a group basis, and

Whereas, additional benefits of this type of group savings would include servicing, increased values on retirement or liquidation, favored treatment by banks, investment and insurance companies, etc., much of which would not be available to us as individuals, and

Whereas, the intent of the committee is to adhere to the interpretation of HR-10 as written into its code by the Internal Revenue Service; therefore be it

Resolved, that the Committee on Retirement Plan for Physicians be authorized and empowered by the House of Delegates to set up and implement a plan of retirement for the physicians of New Jersey on a group and voluntary basis, which shall meet the requirements of the appropriate Internal Revenue Code; and be it further

Resolved, that, once the plan has met the foregoing requirements, its availability to the membership on an entirely voluntary basis be publicized in the *Newslettter* and THE JOURNAL of The Medical Society of New Jersey.

First Resolved paragraph amended by addition of ". . . which shall meet the requirements of the appropriate Internal Revenue Code, and be submitted for review and approval by the Board of Trustees of The Medical Society of New Jersey; and"

Adopted as amended. (page 341)

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

Royal A. Schaaf, M.D., President, Board of Governors

(Reference Committee "C")

Medical Service Administration of New Jersey presents herewith its report for 1962 on the administration of the Medicare Program of the United States Government, and the City of Newark Medical Plan.

MEDICARE PROGRAM

Medical Service Administration of New Jersey in 1962, completed its sixth year as Fiscal Agent for The Medical Society of New Jersey in administering the physicians' portion of the Medical Care Program for dependents of members of the armed services. Under this program, dependent spouses and children of persons in active military service qualify for medical, surgical, obstetrical and hospital services rendered by civilian physicians and hospitals at the expense of the Federal Government.

Contract

The Medicare contract under which Medical Service Administration operated, expired June 30, 1962. A new proposed contract, submitted by the Office for Dependents' Medical Care, limited reimbursable administrative costs to a maximum of $2.50 per claim, which was unacceptable to Medical Service Administration.

As the result of negotiation between Medical Service Administration and the Office for Dependents' Medical Care, this provision of the contract was amended to raise the reimbursable cost per claim to $3.00. Execution of the new contract was accomplished by Medical Service Administration of New Jersey, The Medical Society of New Jersey and the United States Government, Department of the Army, under date of July 1, 1962.

Subsequently, Medical Service Administration, as Fiscal Administrator, renewed the subcontract with Hospital Service Plan of New Jersey for the performance at cost of the administrative services under the Prime contract, which services are being performed in the name of Medical Service Administration of New Jersey.

Schedule of Allowances

The Schedule of Allowances for services performed under the Medicare Program, which was negotiated with the Department of the Army by the Special Medicare Committee of The Medical Society of New Jersey, has remained unchanged since 1958. The fees compare favorably with those provided by Medical-Surgical Plan of New Jersey for similar procedures.

Provision for Adjustment of Fees

When, because of unusual procedures, a physician believes he is entitled to a fee in excess of that provided under the Schedule of Allowances, he may submit a Special Report to Medical Service Administration. Such a report is referred to the Special Medicare Committee of The Medical Society of New Jersey for review and recommendation. The Committee's recommendation is then forwarded to the Federal Government, which subsequently notifies Medical Service Administration of the amount to be paid to the physician.

Practically without exception, the Office of Dependents' Medical Care has concurred in the recommendation of the Committee.

Revised Claim Forms

A revised claim form, Statement of Services Provided by Civilian Medical Sources, (DA 1863 form) became effective January 1, 1962. A supply of the new forms may be obtained by request to Medical Service Administration. As an item of information, a separate form, DA 1863-1, blue colored, has been provided to report Medicare services rendered by hospitals.

Radiation Therapy Authorized

The Medicare contract has been amended to provide authorization for *Radiation Therapy* as follows:

1. *Prior to Hospitalization*—Allowable, effective July 1, 1962, on an outpatient basis when followed by authorized hospitalization for treatment of the condition for which the radiation therapy was prescribed. Payment cannot be made until after a period of authorized hospitalization for the condition is commenced.

2. *During Hospitalization*—Allowable, effective December 7, 1956, when prescribed as part of the course of treatment during authorized hospitalization.

3. *After Hospitalization*—Allowable, effective December 7, 1956 on an outpatient basis when the course of treatment is prescribed or initiated during a course of authorized hospitalization.

Dissemination of the above information to the physicians of New Jersey was accomplished by publication in The Medical Society of New Jersey *Membership Newsletter* Number 147, dated September 1962.

Statistical Data

A statistical review of the Medicare Program in New Jersey since its inception in December, 1956, is presented herewith:

CLAIM EXPERIENCE

Period	Received	Declined	Incomplete	Paid Claim	Paid Amount	On Hand
Dec. 7, 1956 - Dec. 31, 1957	10,017	320	3,179	5,982	489,265	356
Jan. 1, 1958 - Dec. 31, 1958	14,014	377	3,758	9,298	778,551	1,082
*Jan. 1, 1959 - Dec. 31, 1959	7,384	385	1,972	5,908	494,691	206
**Jan. 1, 1960 - Dec. 31, 1960	7,925	197	2,384	4,930	413,687	610
Jan. 1, 1961 - Dec. 31, 1961	7,241	244	1,921	5,681	466,848	5
Jan. 1, 1962 - Dec. 31, 1962	9,508	361	2,140	6,133	510,844	906
TOTAL	56,089	1,884	15,354	37,932	$3,153,886	906

*Effective October 1, 1958, certain types of care were no longer authorized in civilian facilities.
**Effective January 1, 1960, certain of the benefits curtailed in October 1958 were restored for Government coverage.

It will be noted that of the 9,508 physicians' claims received in 1962, 2,140, or more than 22 per cent have had to be returned as incomplete or incorrect. Although the ratio of returned claims has somewhat decreased in 1962, as compared to prior years, it is hoped that with more general use of the new revised claim form D.A 1863-2, prepared for the exclusive use of physicians and dentists, the number of returned claims will decrease significantly.

1,772 physicians received payment in 1962 for services rendered under the Medicare Program.

ADMINISTRATIVE EXPENSE

Period	Amount	Cost per Case
Dec. 7, 1956 - June 30, 1957	$ 19,670	$11.44
July 1, 1957 - June 30, 1958	28,796	3.21
July 1, 1958 - June 30, 1959	31,983	3.77
July 1, 1959 - June 30, 1960	17,383	3.74
July 1, 1960 - June 30, 1961	17,448	3.39
July 1, 1961 - June 30, 1962	17,240	2.94
	$132,520	

The foregoing administrative expense data reflect the initial costs accrued in promulgating the program in New Jersey (contract negotiations, printing, distribution of manuals, and training), and the subsequent additional costs in connection with printing and distribution of new manuals and schedules of allowances. The cost of $2.94 per case for the fiscal year ending June 30, 1962, was the lowest to date, and a constant rate is indicated for the remainder of calendar 1962.

NEWARK MEDICAL PLAN

Forty physicians participated in 1962 in the City of Newark Medical Plan, which provides for medical services rendered in the homes of indigent and medically indigent persons by physicians of the patient's choice on a fee-for-service basis; where a patient has no family physician, a telephone call to the Newark Division of Health will bring a physician to the home.

The classification of *indigent* is applied to those persons whose names appear on the Welfare Rolls of the City of Newark; the *medically indigent* are those who are considered by the City Division of Health as having income sufficient to meet the necessities of an adequate standard of living, but insufficient to pay for needed medical care.

The problem of reaching physicians for weekend or night calls received the helpful attention of the Essex County Medical Society; for several months the Society's Bulletin carried a full-page notice of the opportunity for service under the Plan, with gratifying results. Medical Service Administration expresses to the Essex County Medical Society deep and sincere appreciation for the sensitive understanding of the function of the Administration.

Approved services rendered from January 1 to December 31, 1962, as compared with former years, were:

	RELIEF				
Year	1958	1959	1960	1961	1962
Number of cases served	1655	2154	1654	1484	1151
Value of approved services	$7,630	$10,791	$7,417	$6,914	$5,329
	MEDICALLY INDIGENT				
Number of cases served	3703	3425	2553	1732	1252
Value of approved services	$15,420	$16,439	$11,979	$8,197	$5,999

In 1962, Medical Service Administration received from the City of Newark $12,842.50 for services rendered from November, 1961 through October 1962; this amount was allocated as follows:

	For Physicians' Fees	Plus 10 Per Cent Service Charge (In ome to MSA)	Representing Number of Visits
Division of Welfare (Relief)	$5,505.00	$ 550.50	1,179
Division of Health (Med. Ind.)	6,170.00	617.00	1,289
TOTAL	$11,675.00	$1,167.50	2,468

In the foregoing record, Medical Service Administration of New Jersey has continued to demonstrate its value to the physicians of New Jersey. In successfully implementing the Medicare Program on a Federal level, and the City of Newark Plan on a municipal level, its effectiveness as an agency of The Medical Society of New Jersey has been abundantly manifest. As a Fiscal Administrator through which payments for medical and surgical care may be made by agreements with governmental agencies at Federal, State or other levels, to individuals and groups who might otherwise be unable to obtain protection against illnesses on a non-profit voluntary prepayment basis, Medical Service Administration has gained the acceptance of the medical profession and the public it serves.

Approved (page 339)

MEDICAL-SURGICAL PLAN OF NEW JERSEY

Nicholas F. Alfano, M.D., President, Newark

(Reference Committee "C")

In 1962, a year during which the spotlight of public attention was focused as never before upon the subject of medical care, it is of particular significance that Medical-Surgical Plan of New Jersey registered some of the greatest advances in its history. A substantial record of growth and progress in the Plan's 20th year of service to the community is reflected in this report . . . a record in which The Medical Society of New Jersey can share the Plan's justifiable pride of accomplishment, which was in large part made possible by the Society's continuing cooperation and support.

Growth of the Plan . . . in number of subscribers . . . benefits paid for services to subscribers and their dependents . . . number of physicians' services paid for . . . and number of Participating Physicians enrolled . . . outstripped that of any previous year. More importantly, significant progress was achieved in broadening the services of the Plan to the people of New Jersey.

A particularly heartening note was improvement in the state of the Plan's financial health. After three consecutive years of deficit operations, 1962 ended with a slight gain in reserves. This reflected the impact of the modest rate increase granted in 1961, which took effect over the 12 months ending May 1, 1962, as well as the substantial gain in enrollment during the year.

The Plan's policy of keeping well abreast of fast-changing times was strikingly illustrated early in 1962 when announcement was made in the press by the American Medical Association and the National Association of Blue Shield Plans of a projected national program for Senior Citizens. Although Medical-Surgical Plan already offered protection to those aged 65 and over, the Plan was among the first in the nation to align itself with the national Senior Citizen program of broadened coverage. In an atmosphere charged with political representations and misrepresentations, heightened by emotional concern over care of the elderly, the Plan's prompt and affirmative action was of great public relations value, as evidenced by widespread recognition and approbation in the press.

The problems of mounting such a program, considerable as they were, were overcome before year's end. In this The Medical Society of New Jersey played a leading role through its endorsement and supportive actions.

A less heralded but equally satisfying step forward was the introduction of a special program for college students, offered at lower than standard rates because of the good health record of this age group. Approval of such a program had been sought by Medical-Surgical Plan for several years, and the gratifying response to it was testimony to the need that the Plan had recognized and worked toward fulfilling.

The yardsticks which have measured the Plan's steady growth over two decades showed for 1962 new peaks in service and operational functions. Starting the year with the greatest enrollment increase for the preceding 12 months of any Blue Shield Plan in the United States, Medical-Surgical Plan forged ahead early in 1962 to move up from seventh to sixth largest Plan in the United States. During 1962, the Plan's numerical growth was even larger than in the preceding year, with a gain of over 107,000 subscribers and enrolled dependents, ranking near the top among all Blue Shield Plans in the country

Service to our members concurrently set a new high in benefits paid, which amounted to $37.7 million in payment for 666,615 services rendered by physicians, whose participation in the Plan also set a new record of more than 6,700 enrolled.

The year also was marked by progressive moves internally. The Board of Trustees, recognizing that the magnitude of Plan operations had reached a stage that required the broadening of executive responsibilities, established the office of President as a full-time salaried position and elected to it the Plan's Executive Vice-President and Medical Director, at the same time naming the former President as Chairman of the Board.

The Board also named to the post of Executive Vice-President the Plan's Administrator, who had ably directed its operating sections for the preceding five years.

A much-needed improvement was made in the operational facilities of the Plan's headquarters. Unexpectedly rapid growth of Medical-Surgical Plan during the five years since occupying the new building at 500 Broad Street, Newark, necessitated personnel expan-

sion which ultimately overcrowded the Plan's quarters. This temporarily halted further personnel additions, thereby impeding some operations, until a move was completed late in 1962 to more adequate quarters on the building's top floor. The Plan's attractive new home has more light as well as more space, and has contributed to increased operational efficiency.

The accomplishments of the year were indeed many, but it would not be accurate to convey the impression that all was smooth sailing. Those who would substitute bureaucratic control for voluntary mechanisms of medical care were increasingly active, and the Plan continued to remain alert to such threats and to take positive action where indicated. It also became apparent that the foes of the voluntary nonprofit system are not confined to adherents of the socialistic approach, as legislation vital to the well-being of the Plan ran into roadblocks, despite its sponsorship by the Legislature's own Commission which was created to find ways to contain rising health care costs.

The road ahead to continued growth and greater service . . . perhaps even to survival . . . seems certain to become ever more thorny. Yet Medical-Surgical Plan since its founding has surmounted obstacles that seemed insurmountable, and today occupies a position that would have seemed unbelievable 20 years ago. With such a heritage of dedication and accomplishment . . . buttressed by the support and cooperation of Participating Physicians and The Medical Society of New Jersey . . . the able and loyal service of our operating staff . . . the cooperation of the Hospital Service Plan of New Jersey . . . the Plan will continue to accept and meet the future's challenges to seek new ways of better serving the public and the medical profession.

NOTE REGARDING ENROLLMENT GAIN

The Plan's enrollment gain for 1962 is cited in the accompanying Message from the President as being over 107,000. However, a recheck subsequent to preparation of the Message indicated the correct figure to be 145,473, and this figure is used in the Comparative Statement of Operations for 1962 and in the enrollment graph. Time did not permit revising the figure in the Message prior to this distribution, but the figure of 145,473 will appear throughout the final version of the Annual Report as presented to The Medical Society of New Jersey.

COMPARATIVE BALANCE SHEET DECEMBER 31, 1962

ASSETS

	Dec. 31, 1962	Dec. 31, 1961
1. Cash on Hand and in Banks (Working Funds)	$ 612,316	$ 95,071
2. Investments	12,033,098	11,432,836
Accounts Receivable:		
3. Subscriptions	874,707	737,598
4. Workmen's Compensation	41,055	26,862
5. Federal Employee Program	437,113	566,157
6. Miscellaneous	685	774
7. Accrued Interest and Dividends Receivable	101,071	89,139
TOTAL ASSETS	$14,100,045	$12,948,437

LIABILITIES

1. Claims Outstanding:				
2. Reported	$1,795,000		$ 2,051,000	
3. Unreported	4,855,000	$ 6,650,000	4,060,000	$ 6,111,000
4. Unearned Subscriptions		1,572,876		1,353,751
5. Accounts Payable—Hospital Service Plan		336,265		84,427
6. Accounts Payable—Miscellaneous		178,735		166,070
TOTAL LIABILITIES		$ 8,737,876		$ 7,715,248

RESERVES

1. Securities Evaluation	$ 361,000	$ 343,000
2. Special Contingent	100,000	100,000
3. Unassigned	4,901,169	4,790,189
TOTAL RESERVES	$ 5,362,169	$ 5,233,189
TOTAL LIABILITIES AND RESERVES	$14,100,045	$12,948,437

ANNUAL STATISTICS 1962

TABLE 1.

Paid 1962	Total Services	Per Cent All Services	Payment	Per Cent	Payment Per Service
Surgical	300,031	46.8%	$18,286,825	51.1%	$60.95
Medical	137,957	21.5	7,773,473	21.7	56.35
Obstetrical	45,673	7.1	6,289,165	17.6	137.70
Consultations	39,632	6.2	605,737	1.7	15.28
Anesthesia	118,425	18.4	2,831,977	7.9	23.91
TOTAL	641,718	100.0%	$35,787,177	100.0%	$55.77

Table 1 exeludes Federal claims data.

TABLE II.

DISTRIBUTION OF RIDER SERVICES AND PAYMENT

	Total Services	Per Cent All Services	Payment Amount	Payment Per Cent	Payment Per Service
Surgical	5,567	17.9%	$112,587	20.3%	$20.22
Medical	1,336	4.3	79,816	14.4	59.74
Diag. X-ray	13,103	42.2	242,212	43.7	18.49
X-ray Therapy	119	0.4	13,303	2.4	111.79
Physical Therapy	1,121	3.6	27,957	5.0	24.95
Pathology	9,806	31.6	78,468	14.2	8.00
TOTAL	31,052	100.0%	$554,343	100.0%	$17.85

TABLE III.

DISTRIBUTION OF EARNED SUBSCRIPTION INCOME

Earned Subscription Income	$41,380,643	100.0%
Incurred Claims	37,752,559	91.3
Operating Expense	3,695,125	8.9
Underwriting Loss	67,041	.2

DISTRIBUTION PER DOLLAR OF INCOME

	Cents
Surgical	46.6
Medical	19.8
Obstetrical	16.1
Anesthesia	7.2
Consultations	1.6
Operating Expense	8.9
Underwriting Loss	0.2

FEDERAL EMPLOYEE PROGRAM

The Plan has participated in the underwriting of the Government-Wide Service Benefit Program for Federal Employees since its inception in July, 1960. Initially only basic benefit claims were serviced locally and all supplemental benefits (major medical) claims were required to be sent to the Administrative Agency in Washington.

As of April, 1961, arrangements were concluded for the administration of the supplemental benefit claims as well by the Plan. This has resulted in better claim service for the Federal Employees in New Jersey, and has helped to emphasize this Plan's identification with the nation's largest health benefit program.

During 1962, the Plan paid over 23,000 cases under the Federal Employees Program. The following is the statement of income and expense:

Income	$1,617,610.87	100.0%
Claims Incurred	1,515,382.31	93.7
	$ 102,228.56	6.3%
Operating Expense	77,274.30	4.8
Gain	$ 24,954.26	1.5%

PAID BASIS

Average Exposure (Persons)	106,775
Claim Incidence per 1,000 Persons Enrolled	218
Average Cost per Case	$69.03
Number of Cases	23,284
Amount Paid	$1,607,382

PUBLIC RELATIONS PROGRAM

The first full year of operations by the Medical-Surgical Plan Public Relations Office was an extremely active one. It was a year which saw the topic of health care protection, particularly in relation to older persons, projected into the center stage of public attention, thus creating a volatile public relations situation for Blue Shield, the medical profession, and the voluntary system of medical practice. As pressure for socialized health care of the elderly intensified, it became obvious that Blue Shield, backed by organized medicine, offered the one effective vehicle for preserving the voluntary system.

Medical-Surgical Plan was one of the first Blue Shield Plans in the country to correctly appraise the public relations implications of the situation, and to address itself quickly to positive action. This approach resulted in widespread attention and favorable reaction in the press.

Other activities and events which were extensively publicized included the new Medical-Surgical Plan administrative alignment, which established the Plan's first full-time salaried President and first Chairman of the Board . . . election of new Trustees . . . forthright opposition to legislation inimical to the Plan . . . enrollment gains which moved Medical-Surgical Plan up to sixth largest Blue Shield Plan in the nation . . . new records set in benefits paid and services rendered . . . and introduction of the new Senior Citizen and Student Contracts. Of particular note was publication of an extensive feature interview with the new President which contributed substantially to a favorable "image" of the Plan.

In addition to generating favorable press coverage, the Public Relations Office also performed the "watch-dog" functions of following up and correcting erroneous concepts and statements regarding the Plan. Mindful that one of its basic responsibilities is to clarify and keep clarified the identity of Medical-Surgical Plan, the office consistently aimed at this in preparing or revising news releases, literature, letterheads, newspaper advertisements, radio commercials, and other forms of communications. At the same time a harmonious and effective working relationship with Hospital Service Plan Public Relations, enhanced by fine cooperation from that office, produced successful coordination between the two offices on projects affecting both Plans jointly.

Two new programs in the communication area, generated in 1962, were received favorably. A True-or-False Quiz was provided to Participating Physicians for distribution to patients in waiting rooms, and was accorded an enthusiastic response by the physicians, who requested 50,000 additional copies; in this project the Public Relations Office enjoyed the guidance and assistance of the Public Relations Committee Chairman.

A new publication for New Jersey physicians, "New Jersey Blue Shield Pulse," designed in magazine format and inaugurated on a quarterly basis, elicited favorable comment from physicians, Plan personnel, and other Plans.

Internally, the Public Relations Office contributed editorial assistance and counsel to all

areas of the Plan concerned with communications. Functions included editorial supervision of all Plan literature and printed material, including brochures, leaflets, form letters, special reports and mass mailings . . . participation in planning the annual advertising campaign with Hospital Service Plan, and preparing advertisements for newspapers, radio, billboards, bus cards, etc. . . . dealing with "problem" correspondence from subscribers and physicians, as well as letters of gratitude . . . participating with Hospital Service Plan in the editorial supervision and writing of "Fast Facts" and "Two Blues News" . . . designing Plan displays . . . and many other activities.

It is believed that the Plan's Public Relations Office in the past year has demonstrated itself as effectively projecting and protecting a favorable concept of Blue Shield, as well as providing substantial assistance and counsel in the Plan's operations.

CLAIMS INCURRED

Year	Amount
1962	$37,753,000
1961	34,575,000
1960	31,516,000
1957	22,886,000
1954	13,992,000
1951	6,527,000
1948	1,204,000
1945	208,000
1942	5,000

INCIDENCE RATE PER THOUSAND PERSONS ENROLLED

Year	Incidence
1962	182
1961	177
1960	166
1956	143
1954	126
1951	112
1948	96
1945	86
1942	40

PHYSICIAN RELATIONS PROGRAM

Last year the Physician Relations Section accomplished its objective of maintaining liaison and cooperation between the Plan and its Participating Physicians.

It is noteworthy that at year's end the number of Participating Physicians stood at a new high of 6,707, a gain over 1961 of 143. Represented in the total are 5,920 Doctors of Medicine, 439 Doctors of Osteopathy and 348 Doctors of Surgical Chiropody. Over 80 per cent of the eligible physicians in New Jersey participate in the Plan.

The total number of contacts made by the Plan's Field Representatives during 1962 was 3,238. The most common avenue of communication utilized for these field contacts was meetings with the medical staffs of hospitals throughout the state. The Field Representatives established an information desk in the physicians' lounge for several hours or addressed a Medical Staff Meeting. During the course of these hospital visits many facets of Plan policy and procedure were discussed in detail.

During 1962, the Physician Relations Section initiated or received over 13,000 telephone calls from physicians or their assistants. This method of personal communication played an important part in the maintenance of close liaison between the Plan and the medical profession.

The interest shown by physicians to our Physician Relations Program has been gratifying. Evidence of this is reflected in the cooperation of medical staffs in scheduling visits to their respective hospitals, their enthusiasm during the course of these hospital meetings, and many phone calls received.

We believe that each personal contact made during 1962 helped the medical profession to better understand Blue Shield philosophy, policies and procedures, and the Plan's value to the citizens of New Jersey.

ENROLLMENT GROWTH

Year	Enrollment
1962	2,322,152
1961	2,176,679
1958	1,830,397
1954	1,196,804
1951	669,906
1948	236,604
1945	49,441
1942	4,131

NEW JERSEY PARTICIPATING AND NON-PARTICIPATING PHYSICIANS BY COUNTY

	County	Total Eligible Phys.	PARTICIPATING Total	M.D.	D.O.	D.S.C.	NON-PARTICIPATING Total	M.D.	D.O.	D.S.C.	% P.P. As Of 12-31-62	% P.P. As Of 12-31-61
1	Atlantic	222	206	175	18	13	16	16			92.8	92.7
2	Bergen	989	660	571	53	36	329	310	17	2	66.7	67.4
3	Burlington	198	175	143	23	9	23	19	4		88.3	87.5
4	Camden	560	488	352	109	27	72	67	3	2	87.1	88.6
5	Cape May	68	62	51	8	3	6	4	2		91.1	90.6
6	Cumberland	116	113	103	3	7	3	2	1		97.4	97.4
7	Essex	1694	1373	1250	52	71	321	309	10	2	81.0	82.0
8	Gloucester	119	101	75	17	9	18	13	5		84.8	86.3
9	Hudson	733	602	556	8	38	131	128	2	1	82.1	82.1
10	Hunterdon	66	63	62	1		3	3			95.4	95.2
11	Mercer	443	362	339	8	15	81	75	6		81.7	83.2
12	Middlesex	386	307	280	11	16	79	78		1	79.5	82.2
13	Monmouth	408	328	297	16	15	80	77	3		80.3	80.3
14	Morris	339	281	255	17	9	58	53	4	1	82.8	83.1
15	Ocean	120	97	89	5	3	23	23			80.8	86.2
16	Passaic	612	462	415	15	32	150	144	4	2	75.5	75.8
17	Salem	51	48	40	6	2	3	3			94.1	88.7
18	Somerset	138	110	103	4	3	28	28			79.7	79.7
19	Sussex	48	43	39	2	2	5	5			89.5	91.6
20	Union	742	540	470	32	38	202	197	4	1	72.7	72.5
21	Warren	47	45	43	2		2	2			95.7	96.0
22	Out of State	251	241	212	29		10	10			96.0	96.5
	TOTALS	8350	6707	5920	439	348	1643	1566	65	12	80.3	81.0

COMPARATVE SUMMARY OF OPERATIONS

	1962			1961	
Subscriptions Earned*		$41,380,643	100.0%	$36,183,635	100.0%
Less:					
Claims Incurred	$37,752,559**		91.2	$34,574,745	95.6
Operating Expenses	3,695,125***		8.9	3,269,835	9.0
		41,447,684	100.1	37,844,580	104.6
(Loss) from Underwriting Operations		(67,041)	(.1%)	(1,660,945)	(4.6%)
Income on Investments		383,981		383,604	
Operating Gain (Loss) for the Year		$ 316,940		($ 1,277,341)	

* The gain of $5,197,008 in subscriptions earned (not including Federal Employee Contracts) reflects gains in enrollment, which increased by 145,473 during the year, and an average rate increase of 15.7 per cent that became effective with contracts having anniversary dates on and after May 1, 1961.

** The rise of $3,177,814 in claims incurred is attributable to increased exposure from larger enrollment and to increased incidence, which rose from 177 per 1,000 persons to 182.

*** The increase of $425,290 in operating expenses is caused by increased services rendered by Hospital Service Plan in the amount of 381,143 and a rise of $44,147 in Medical-Surgical Plan direct expenses. Based on subscriptions earned, total operating expense decreased by one-tenth of one per cent.

SUMMARY OF RESERVES FOR PROTECTION OF SUBSCRIBERS

	1962	1961
Reserves at January 1	$ 5,233,189	$ 6,885,000
Operating Gain (Loss) for the Year	316,940	(1,277,341)
	5,550,129	5,607,659
Plus (Minus): Change in Non-Admitted Assets	(187,960)	(374,470)
Reserves at December 31	$ 5,362,169*	$ 5,233,189

* The increase of $128,980 in reserves for the protection of Plan subscribers is caused by a net operating gain of $316,940 less downward reserve adjustments totaling $187,960.

1962 BOARD OF TRUSTEES

Chairman of the Board

Royal A. Schaaf, M.D. (1965)

First Vice-President

Thomas J. White, M.D. (1965)

Second Vice-President

Rudolph C. Schretzmann, M.D. (1965)

Secretary-Treasurer

John S. Thompson (1965)

MEMBERS

Charles W. Barkhorn, M.D.	(1963)
Irving P. Borsher, M.D.	(1963)
F. Clyde Bowers, M.D.	(1963)
Robert G. Boyd	(1963)
Charles L. Cunniff, M.D.	(1963)
Andrew P. Dedick, Jr., M.D.	(1963)
Joseph P. Donnelly, M.D.	(1964)
Joseph I. Echikson, M.D.	(1964)
Jerome G. Kaufman, M.D.	(1964)
Joseph M. Keating, M.D.	(1964)
Elton W. Lance, M.D.	(1964)
Samuel J. Lloyd, M.D.	(1964)
Jesse McCall, M.D.	(1964)
Duane E. Minard, Jr.	(1965)
Glennis S. Rickert, M.D.	(1965)
Edward W. Sprague, M.D.	(1965)
David L. Yunich	*(1965)
Louis S. Wegryn, M.D.	**(1963)
Gustave E. Wiedenmayer	(1963)

* Resigned 1963
** President of The Medical Society of New Jersey

ADVISORS TO THE BOARD OF TRUSTEES

	Appointed	Term as Board Member
Harry N. Comando, M.D.	1959	1942-1958
William F. Costello, M.D.	1958	1948-1958
William E. Dodd, M.D.	1952	1944-1952
Arthur W. Lunn	1962	1951-1962

FORMER MEMBERS OF THE BOARD OF TRUSTEES

David B. Allman, M.D.	1945-1945
*Theophilus H. Boysen, M.D.	1944-1945
Lewis W. Brown, M.D.	1949-1954
*William J. Carrington, M.D.	1942-1943
*Patrick H. Corrigan, M.D.	1952-1958
*Samuel A. Cosgrove, M.D.	1944-1953
William K. Harryman, M.D.	1944-1945
Sigurd W. Johnsen, M.D.	1950-1951
*Augustus S. Knight, M.D.	1942-1948
*Thomas K. Lewis, M.D.	1942-1949
Paul Mecray, Jr., M.D.	1953-1961
*Norman M. Scott, M.D.	1942-1950
Reuben L. Sharp, M.D.	1950-1951
James H. Spencer, M.D.	1957-1961
*Carl K. Withers	1952-1961

* Deceased

OFFICERS

Nicholas F. Alfano, M.D.
President and Medical Director

John S. Robinson
Executive Vice-President

John S. Thompson
Secretary-Treasurer

Approved. Royal A. Schaaf, M.D. especially commended for his long, excellent, and continuing service in the development and growth of Medical-Surgical Plan. (page 339)

Reference Committee Reports • • •

REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

Merton L. Griswold, Jr., M.D., Chairman, pro tem

The Reference Committee on Constitution and Bylaws met at 11:00 a.m., Sunday, May 12, 1963. Committee members present were: Dr. Ornaf, Dr. Bythewood, and Dr. Driggs. In the absence of the chairman, Dr. Griswold was elected chairman, pro tem.

1. Implementation of Constitutional Amendment (page 271)

This item from the Board of Trustees—Implementation of Constitutional Amendment, Article IV, Section 4—which dealt with the apportionment of delegates by the component societies, was considered. The report and recommendations of the special committee appointed by the Board of Trustees were approved by the reference committee, and were **recommended** for submission to the House of Delegates for its approval.

Adopted

2. Committee on Revision of Constitution and Bylaws (page 287)

The items on Application for Membership and Proposed Amendments to the Bylaws were considered:

A. Chapter IX, Section 10, Committee on Credentials

The change in the Bylaws, Chapter IX, Section 10, as delineated in the 1963 annual reports, was approved and the proposed amendment pertaining to the functions of the Committee on Credentials was **recommended** for submission to the House of Delegates for approval.

Current

(c) The Committee on Credentials shall review and act upon all applications for membership in component societies. It shall report its actions in writing to component societies.

Proposed

(c) The Committee on Credentials shall review and pass upon the formal credentials of all applicants for membership in component societies. It shall report its findings in writing to the component society concerned.

Adopted

B. Chapter XI, Section 2—Qualifications of Members

The second proposed amendment to the Bylaws pertaining to the component societies as to qualifications of members in Chapter XI, Section 2 of the Bylaws, was also approved by the reference committee and **recommended** for submission to the House of Delegates for approval.

Current

(a) Each component society shall judge the qualifications of its applicants for membership, but election to any type of membership shall be contingent upon review and approval by the Committee on Credentials of this Society.

Proposed

(a) Component societies shall have the responsibility to judge the qualifications of an applicant for any type of membership and alone shall have the power to elect him, but election thereto shall be contingent upon clearance of each eligible applicant's formal credentials as satisfactory by the Committee on Credentials of this Society.

Adopted

C. Signatures on Checks (page 288)

The action of the Board of Trustees in authorizing the chairman of the Committee on Finance and Budget to sign checks in the absence of the Treasurer was approved, and it was **recommended** that it be approved by the House of Delegates.

Adopted

Report adopted as a whole.

REFERENCE COMMITTEE "A"

Joseph M. Gannon, M.D., Chairman

Reference Committee "A" met on Sunday, May 12, at 11:00 a.m. Present were Doctors William E. Bray, Ralph E. Siegel, J. Lloyd Morrow, and the chairman. Approximately 20 delegates and members were present to discuss the various items under consideration.

1. **President** (page 258)

This report was read in its entirety by the chairman inasmuch as it epitomizes the many problems with which the President is confronted. For all the time and effort that Doctor Wegryn has expended in behalf of this Society, we as a committee commend him. The committee **recommends** approval of his report.

Adopted

2. **Board of Trustees** (page 264)

The introductory portion of this report, covering the general activities of the Board, was reviewed and approved. We **recommend** approval of this portion of the report.

Adopted

A. **AMA Lists of Physicians** (page 264)

Information received from the AMA regarding this subject was reviewed. No recommendation developed from consideration of this information. We **recommend** approval of this portion of the report.

Adopted

B. **D.O. to M.D. Conversion in California** (page 265)

Most of the time of the open meeting of the reference committee was spent in discussing this item of the Board's report which concerns itself with a recommendation that certain holders of an M.D. degree from the California College of Medicine, granted under a special program terminated on September 20, 1962, be considered to have an M.D. degree acceptable to this Society, provided that such person agree in writing to use the M.D. degree exclusively thereafter.

Most of the consideration and arguments offered pro and con in this matter appeared to be based on legal rather than medical and professional grounds. The committee likewise spent most of its time in discussion of this item of business, and agreed that:

(1) Until such time as the official body which we accept for the accreditation of medical schools approves the California College of Medicine specifically in its action of granting the M.D. degree to 2,100 graduates of osteopathic schools in July 1962; and

(2) Until the State Board of Medical Examiners qualifies one or more of these graduates as an M.D., the reference committee advises against the acceptance of the following recommendation of the Board of Trustees:

> That any person fully licensed as a physician and surgeon by the State Board of Medical Examiners of New Jersey, licensed originally as holding a D.O. degree but who subsequently converted the D.O. degree to an M.D. degree through the California College of Medicine under its special program terminated on September 20, 1962, be considered to have an M.D. degree acceptable to this Society, provided that such person agree in writing to use the M.D. degree exclusively hereafter.

The reference committee therefore **recommends** disapproval of this portion of the report.

Amended to "recommend approval of this portion."

Adopted as amended.

The reference committee further suggests that the Board of Trustees and Society's Legal Counsel enter into consultation with an eminent legal counsel prior to taking any further steps aimed at implementing the recommendation previously stated in the report.

Amended by deletion of "with an eminent legal counsel."

The committee **recommends** approval of this portion of the reference committee report.

Adopted as amended.

3. **Secretary** (page 259)

This report was thoroughly considered, and the committee **recommends** approval of it in its entirety.

Adopted

4. **Judicial Council** (page 272)

The committee reviewed and discussed thoroughly the report of the Council, including its items concerning the revisions of the Regulations, the tabling of the use of waiver forms, and its opinion regarding the physician's charging for medical services to dependents of other physicians. We **recommend** approval of the report.

Adopted

5. **Executive Director** (page 273)

The report of the Executive Director was reviewed and approved. The committee expresses its thanks to Mr. Nevin for his help and guidance to this committee, and wishes to note that his new title of Executive Director is consistent with the esteem in which he is held by our Society. We **recommend** approval of his report.

Adopted

6. **Credentials** (page 277)

This report was reviewed and approved by the committee. We **recommend** its approval.

Adopted

7. **Responsibility of AMA Delegates, Resolution #15** (page 323)

The reference committee **recommends** disapproval of this resolution because of its disagreement with the preamble, even though in general we agree with the resolution itself. We suggest that some further implementation of the present method of reporting by the AMA Delegates be considered.

Adopted

The reference committee **recommends** approval of this portion of its report.

Adopted

Report adopted as a whole as amended.

REFERENCE COMMITTEE "B"

Henry O. von Deilen, M.D., Chairman

Reference Committee "B" met at 11:00 a.m. on Sunday, May 12, 1963, with all members present—Dr. Warren, Dr. D'Elia, Dr. Gullord, Dr. Barbour, and the chairman. Also present were: Dr. Featherston, Dr. Ware, Dr. Davidson, Dr. Graham, Dr. Heller, Dr. O'Connor, Dr. Lloyd, Dr. Mulligan, Dr. Dilger, and Dr. Miller.

1. **Treasurer** (page 260)

The report of the Treasurer was reviewed in detail. We noted with approval that the report covers a 12-month period, as requested last year; also that the report on the Medical Student Loan Fund is itemized in detail.

We **recommend** that the Treasurer's report be approved, and that he be congratulated on his continued good work.

Adopted

2. **Finance and Budget Committee** (page 277)

After lengthy discussion and answer to many questions, the reference committee **recommends** the following:

(1) That the House of Delegates convert into a grant the 1961 loan of $60,000 to the Medical Student Loan Fund.

(2) That the budget for 1963-64 be adopted in the total sum of $242,091.

(3) That the 1964 assessment be adopted at $40 per capita.

(4) That the per capita level of contribution to AMA-ERF for 1964 be set at $5.00 in addition to, and not as part of, the budgetary assessment, and that both be paid at the same time.

Adopted

3. **Medical Student Loan Fund Committee** (page 282)

The reference committee notes with pleasure the progress of the Medical Student Loan Fund under the leadership of Luke Mulligan. We **recommend** that the report be approved.

Adopted

4. **Membership Directory, Resolution #14** (page 322)

The reference committee approved resolution # 14 and **recommends** its adoption.

Adopted

5. **Publication Committee**

A. **Printed Report** (page 285)

The report was reviewed and extensively discussed. We realize that the committee is in a state of transition, and we feel that more time should be given to them due to the projected increase in advertising rates and subscriptions—effective June 1, 1963—before any definite recommendation can be made as to a future course concerning the finances of THE JOURNAL.

We **recommend** that the report be approved as published.

Adopted

B. **Supplemental Report** (page 286)

In its supplemental report, the Publication Committee asked the House to do two things:

(1) Allocate to the Publication Committee an amount equal to $5 per member. The Board of Trustees, in January 1963, set that amount as a fair subscription rate. We do not ask that such funds be actually paid into the JOURNAL account. We simply ask that, in calculating the JOURNAL's financial posture, a credit of $5 a member be allotted. This will bring us in line with what other state journals do.

(2) The Editor's salary should be charged against the JOURNAL. So should the pro rata share of the Assistant Editor's salary. The Executive Director should determine what proportion of the Assistant Editor's time is reasonably charged to the JOURNAL, and that ratio of her salary should be counted as a JOURNAL expense.

The reference committee **recommends** that request #1 be disapproved in accordance with our previous statement concerning the printed report.

Adopted

Request #2 was approved, and we **recommend** its adoption by the House of Delegates.

Adopted

Report adopted as a whole.

REFERENCE COMMITTEE "C"

Robert E. Verdon, M.D., Chairman

Reference Committee "C" met on Sunday, May 12, 1963, in the Mandarin Room. All members of the committee were present—Dr. Albano, Dr. Konzelman, Dr. McCormack, Dr. Davison, and the chairman. The committee considered each of the items referred to it and presents the following report.

1. **Board of Trustees—Items**

A. **Basic Minimum Hospital and Nursing Home Care** (page 266)

The committee affirms the action of the Board of Trustees in that the 1962 resolution be received and noted on the basis that many of its stipulations involve federal governmental agencies and are impossible for the Board to implement. We **recommend** this item be approved.

Adopted

B. **Complaint of Group Health Insurance of New Jersey** (page 265)

The committee is in agreement with the Board of Trustees that Group Health Insurance of New Jersey is an indemnification insurance organization and that, aspiring to be permitted to incorporate as a medical service corporation, it seeks to go beyond the bounds of its purposes and capabilities. We **recommend** approval of this section.

Adopted

C. **Distinction Between Blue Cross and Blue Shield** (page 267)

The committee feels that the Board of Trustees complied with resolution #9 adopted by the 1962 House of Delegates in stipulating that the issuance by Blue Cross of an adequate press release apprising the public of the true cause of the Blue Cross increases. The release further pointed out that the administrative expense of New Jersey hospitals, chiefly payroll, was a basic reason for the necessary increases. It specifically credits the medical profession with cooperation in endeavors to keep the cost of hospitalization within bounds.

Blue Cross and Blue Shield have found separate billings to be economically impractical. At the present time, each subscriber receives with his bill a visual representation of rates for each clause of contract under each Plan. We **recommend** approval of this item.

Adopted

D. **Hospital Service Plan In-Hospital Tests** (page 268)

The committee reviewed resolution #12, as adopted by the 1962 House of Delegates, and

a report of the Hospital Service Plan President. It is the opinion of the committee that it is highly desirable and important for physicians to discuss the Blue Cross contract limitations with their patients before ordering examinations and services.

It is also the opinion of the committee that if, following the present review procedure, the attending physician wishes to protest the Plan's determination, our Medical Advisors will review the case again. Also, the procedure followed by Hospital Service Plan is adequate, practical, and does not incur any additional costs. We **recommend** approval of this item.

Adopted

E. **Medical Service Administration, Board of Governors Nominations** (page 266)

The committee approves the nominations contained on page 10 of the printed material and **recommends** their approval by the House.

Adopted

F. **Medical-Surgical Plan, Board of Trustees Nominations** (page 266)

The committee approves the nominations contained on page 9 of the printed material, with the exception of Dr. F. Clyde Bowers whose resignation has been accepted. The committee was also informed that Dr. Glennis S. Rickert had also resigned and that his resignation had been accepted. With the acceptance of the resignations of Dr. Bowers and Dr. Rickert four vacancies exist on the MSP Board of Trustees. The committee recommends that not more than two of these four vacancies shall be filled by lay members representing subscriber groups.

Amended by deletion of last sentence. Adopted as amended.

The committee also **recommends** that the other nominees listed be approved.

Adopted

2. **Deductible Blue Cross Insurance, Resolution #7** (page 318)

The committee takes cognizance of the existence of a hospital plan contract with deductible features. The committee is also aware of some features of merit in this resolution. However, it is the opinion of the committee that gradual and complete abandonment of the comprehensive plan and substitution of the modified deductible plan would not be feasible and might well be disastrous.

The committee, realizing the importance of continuing study and investigation of utilization of hospital beds, **recommends** that this particular matter be referred to the Board of Trustees of The Medical Society of New Jersey for further action.

Adopted

The committee **recommends** that this resolution be not adopted.

Adopted

3. **Medical Service Administration** (page 325)

The committee commends the Medical Service Administration for its diligence and efficiency in the administration of the Medicare Program. We **recommend** that the report of the Medical Service Administration be approved.

Adopted

4. **Medical-Surgical Plan** (page 328)

The administration of the Medical-Surgical Plan is to be commended on its substantial growth and progress in the Plan's 20th year of service.

The committee feels that it is worthy of note that 1962 ended with a gain in reserves after three years of deficit operations.

The Plan's alignment with the National Senior Citizens Program of broader coverage was of great public relations value as shown by widespread recognition and approbation in the press. Only prompt and affirmative public relations could have achieved these positive results.

The Board of Trustees of Medical-Surgical Plan, recognizing the need of broadening of executive responsibility, established the office of president as a full-time salaried position and elected to it the Executive Vice-President and Medical Director. It further named the former president to the position of Chairman of the Board. The committee wishes to congratulate both of these men on the assumption of the new offices.

The committee feels that Dr. Royal A. Schaaf should be especially commended for his long, excellent, and continuing service in the development and growth of the Medical-Surgical Plan.

We **recommend** that the report of the Medical-Surgical Plan be approved.

Adopted

Report adopted as a whole as amended.

REFERENCE COMMITTEE "D"

John J. Thompson, M.D. Chairman

The committee was called to order at 11:00 a.m., Sunday, May 12, 1963, Mother's Day. Dr. Akey, Dr. Flynn, Jr., Dr. Kreutz, Dr. Spurgeon, and Dr. Thompson were present. The committee would like to thank the 17 Society members who expressed their opinions. They represented 8 counties, and each one of the members spoke at least one time, and some many times. In all, 36 comments or questions were made.

1. **Acceptance of Qualified Graduates of Foreign Medical Schools for House Staff Training Programs, Resolution #10** (page 320)

The committee unanimously **recommends** acceptance of this resolution by the House of Delegates.

Adopted

The committee further **recommends** to the House of Delegates that Resolution #10 be referred to the Board of Trustees to encompass the intent of this resolution along with Resolution #2—**AMA Intern Approval Program**, from Bergen County—and Resolution #3—**AMA Intern Approval Program**, from Morris County—into one or more resolutions that will be concise, brief, and effective for presentation to the House of Delegates of the AMA at the June 1963 meeting. The intent of these is:

> Resolved, that the House of Delegates of the American Medical Association rescind that action taken in Los Angeles and re-establish educational and qualitative standards as the exclusive criteria governing the operation of, and admission to, approved intern and resident training programs in all hospitals, affiliated or non-affiliated, in the United States.

Adopted

2. **AMA Intern Approval Program, Resolution #2** (page 315)

This resolution from Bergen County was read and studied. The committee unanimously approves the resolution and **recommends** that the intent and resolved be incorporated into one or more resolutions as noted above for Resolution #10.

Adopted

3. **AMA Intern Approval Program, Resolution #3** (page 316)

The resolution from Morris County was reviewed and studied. The committee unanimously approves the resolution and **recommends** that the intent and resolved be incorporated into one or more resolutions as directed for Resolution #10 above.

Adopted

4. **Percentage of Foreign Graduates in Approved Intern and Resident Training Programs, Resolution #11** (page 321)

Resolution #11 from the Board of Trustees was reviewed and studied by the committee. The committee, after deliberation, voted unanimously to disapprove this resolution. The committee sympathizes and agrees with the intent of the resolution, but they believe the best interest of improving our relationship with the medical schools and their graduates would not be served by this resolution. We **recommend** disapproval of Resolution #11.

Adopted

5. **AMA Publicity on Compensation of Interns and Residents** (page 268)

This item from the report of the Board of Trustees was read and studied. The committee voted unanimously to accept the report and commend the representatives of the Board of Trustees for the action that they took. We **recommend** that this item be approved.

Adopted

6. **Internships in Community Hospitals** (page 268)

The committee read and studied this item from the report of the Board of Trustees. The committee unanimously approves this portion of the report and wishes to commend the New Jersey delegates, along with the delegation from California, for the resolution presented to and adopted by the AMA House of Delegates in Chicago. The resolution is:

> Resolved, that the American Medical Association through its Council on Medical Education and Hospitals, continue to create and recommend that medical faculties actively encourage their gradu-

ates to utilize such programs to assure an adequate supply of family physicians.

We **recommend** approval of this item of the Board's report.

Adopted

7. **Rotating Internship in the Community Hospital, Resolution #4** (page 317)

The resolution from Morris County was read and studied by the committee. The committee unanimously voted disapproval of this resolution, for the intent of the resolution has already been expressed to a degree in the foregoing resolution that has been adopted by the AMA House of Delegates. The committee also feels that this resolution could produce a restriction on an individual in the pursuit of his hospital training after finishing medical school. We **recommend** that Resolution #4 be disapproved.

Adopted

8. **Accreditation of Hospitals for the Chronically Ill and Long-Term Patients, Resolution #8** (page 319)

The resolution was read and studied. The committee unanimously voted to **recommend** that this resolution be referred to the Board of Trustees for verification of the facts the resolution presents, as well as to determine what reasons the AMA may have had for withdrawing its support. These facts could not be obtained by the reference committee at its hearing.

Adopted

9. **Medical Education** (page 282)

The report was reviewed and studied by the committee. The committee unanimously approves and accepts this report and wishes to commend the committee for their alertness to action in this problem of the "Intern and Resident Training Programs." We **recommend** adoption of the report.

Adopted

10. **Retirement Plan for Physicians** (page 313)

The report was reviewed and studied. The committee unanimously voted to accept the report and to commend the committee for the inclusive and comprehensive studies they have made and heartily accept and endorse their recommendation:

> That the Special Committee on Retirement Plan for Physicians be empowered to continue to investigate actively all possible avenues of programmed retirement plans at local and state level and to attempt to draw up a model plan for the society membership acting as a group as soon after publication of the Internal Revenue regulations as possible.

We **recommend** approval of the report.

Adopted

11. **Retirement Plan for Physicians, Resolution #18** (page 324)

Resolution #18 was read and studied. The committee unanimously voted to **recommend** that the first "resolved" be changed to read:

> Resolved, that the Committee on Retirement Plan for Physicians be authorized and empowered by the House of Delegates to set up and implement a plan of retirement for the physicians of New Jersey on a group and voluntary basis, which shall meet the requirements of the appropriate Internal Revenue Code, **and be submitted for review and approval by the Board of Trustees of The Medical Society of New Jersey and the House of Delegates of The Medical Society of New Jersey;** and be it further

Amended by deletion of "and the House of Delegates of The Medical Society of New Jersey."

Adopted as amended.

12. **Medical Defense and Insurance** (page 280)

This report was reviewed and studied. The committee unanimously voted approval of the report and **recommends** that efforts be made on a state-wide basis to increase the enrollment of the members of MSNJ in the program offered by the American Mutual Liability Insurance Company. This would provide the company with the most reliable statistics and figures from which they will be able to establish in a final form our rates of payment for this liability coverage.

Adopted

Report adopted as a whole as amended.

REFERENCE COMMITTEE "E"

Nicholas E. Marchione, M.D., Chairman

Reference Committee "E" met on Sunday, May 12, 1963, in the Rowsley Room. All members of the committee were present—Dr. Boylan, Dr. Taylor, Dr. Eckstein, Dr. Ruoff, and the chairman—and 42 members and guests of The Medical Society of New Jersey participated in the discussion. The meeting adjourned at 1:15 p.m.

1. **Board of Trustees—Items**

A. **Annual Meeting Publicity 1962** (page 269)

The committee **recommends** that this report be approved as contained in the printed record.

Adopted

B. **New Jersey Assembly, Resolution** (page 269)

The committee **recommends** that this report be approved as contained in the printed record.

Adopted

2. **Legislation** (page 289)

This reference committee takes a special note of the tremendous volume of legislation which the Council on Legislation has reviewed. It commends the diligent efforts which the Council has put forth to constantly look out for the interests of The Medical Society of New Jersey, keep it informed of pertinent pending legislation, and also in implementing legislation of import to the Society. The committee sincerely thanks Dr. Jesse McCall and the members of his council for the excellence and completeness of their report.

The reference committee **recommends** that this report be approved in its entirety.

Adopted

3. **Public Relations** (page 296)

This committee thanks Dr. John F. Kustrup and his council on the excellent and thorough detailing of his report and commends him for a job well done.

The committee **recommends** that this report be approved as submitted.

Adopted

4. **State-Wide Medical Examiners' System Resolution #1** (page 315)

The reference committee thanks Doctor Breitinecker of Maryland, the invited guest of Burlington County, for appearing before this committee and expressing his views on this subject. It also thanks the member-physicians who participated in the discussion, pro and con.

The committee **recommends** the approval of this resolution from the Burlington County Medical Society.

Adopted

5. **JEMPAC, Resolution #6** (page 318)

The committee **recommends** the adoption of this resolution as presented.

Adopted

6. **Reporting of Epilepsy by Physicians, Resolution #9** (page 319), and **Reporting of Communicable Diseases, Resolution #12** (page 321)

Resolutions #9 and #12 were discussed jointly by this committee. Both these resolutions engendered lively discussion by members of the committee, member-guests, and participants. We especially wish to thank E. Powers Mincher, our Legislative Analyst, for his fortuitous remarks and legislative guidance in our consideration of these resolutions.

The committee **recommends** the approval of Resolution #9 as presented.

Adopted

On the advice of Mr. Mincher, as to the correctness of some of the statements made in Resolution #12, and recognizing that any attempt to change the heading or wording of the resolution would confuse the intent, and with the approval of Dr. Theodore R. Robie, sponsor of the resolution, and other interested doctors present, this committee **recommends** the rejection of Resolution #12 and wishes to present an alternate version which would accomplish the same purpose and fulfill the intent of the resolution as presented by Dr. Robie. Again, this was done with the approval of the originator of the resolution and in accordance with Bylaws, Chapter IX, Section 20—Reference Committees:

(g) A reference committee may recommend deletions, additions, or rephrasings to clarify and accomplish the obvious intent of the referred item, but it may not make changes which will alter the original substance or intent of the referred item. However, it may, at is discretion, recommend an alternate version embracing the views of the reference committee for the consideration of and action by the House of Delegates.

The alternate version follows:

Resolved, that The Medical Society of New Jersey recommend that the three categories of diseases, namely epilepsy, cerebral palsy, and mental deficiency, be stricken as reportable diseases and be it further

Resolved, that the other reportable diseases listed be scrutinized with a view to bring the list of reportable diseases in line with modern medical knowledge.

The committee **recommends** that this alternate version of Resolution #12 be adopted by the House of Delegates.

Adopted

7. **Tuberculosis Control, Resolution #13** (page 322)

The committee wishes to thank Dr. S. William Kalb for his presentation and for making available to the committee material pertinent to the discussion. This reference committee **recommends** the adoption of Resolution #13 —Tuberculosis Control—as presented.

Adopted

8. **Ophthalmic Technicians, Resolution #17** (page 324)

It was pointed out to the member delegates that at present opticians by law are not considered eligible assistants to physicians, that amending legislation is now being considered by the Legislature, and that S-138 has passed the Senate and is expected to be presented to the Assembly on Monday, May 13. This committee **recommends** the approval in principle of Resolution #17.

Adopted

The chairman of the committee wishes to thank the members for their valued and loyal assistance in the conduction of this reference committee.

Report adopted as a whole.

REFERENCE COMMITTEE "F"

John B. Fuhrmann, M.D., Chairman

Reference Committee "F" met at 11:00 a.m. on Sunday, May 12, 1963, with all members present—Dr. Stineman, Dr. Plavin, Dr. Clark, Dr. Tyrrell, and the chairman. During the course of the meeting at least forty officers and members of The Medical Society of New Jersey were in attendance at the meeting. Their participation in the proceedings of the meeting were very instructive and very valuable in our arrival at the following conclusions:

1. **Vendor Payments in Welfare Cases** (page 269)

The reply of the Medical Director of the Division of Welfare, State Department of Institutions and Agencies, was noted with approval, and we **recommend** the acceptance of the reply.

Adopted

2 .**Medical-Legal Testimony** (page 270)

This item is received as a progress report, and we **recommend** that the appearances of a physician and a lawyer member of the committee before County Bar Associations be implemented at the earliest convenience.

Adopted

3. **Council on Medical Services** (page 297)

The committee considered the report of this council in three parts as follows:

A. The matters of concern of the **Council Proper** are noted, and we **recommend** that the council continue with projects of this kind and pursue them to conclusion.

Adopted

B. **Public Medical Care**—The committee feels that this section is of special importance. We feel that all physicians should take advantage of the single monthly billings as noted in part 4, and that every County Welfare Board should be made aware of these facts that have been cleared with the New Jersey State Division of Welfare. We **recommend**:

(1) The approval of this section of the report of the Council on Medical Services, and

(2) That each County Welfare Board be made aware of the items as specified in this section of the report.

Adopted

C. **Physician-Hospital Relationships**—The committee **recommends** the acceptance of this portion of the report as a progress report.

Adopted

We **recommend** approval of the entire report of the Council on Medical Services.

Adopted

4. **Committee on Occupational Health** (page 298)

The committee commends the Committee on Occupational Health for their devotion to their projects and suggests that they implement their suggested articles in THE JOURNAL. We **recommend** the adoption of their report.

Adopted

5. **Committee on Workmen's Compensation** (page 299)

We note with interest the progress that is being made with the touchy problems involved with Workmen's Compensation and congratulate the committee on this progress. We further note the recommendation of this committee that they continue with their consultations and discussions with the various agencies concerned with workmen's compensation problems.

We **recommend** the acceptance of the report and adoption of the committee's recommendation.

Adopted

6. **Union Family Health Groups, Resolution #5** (page 317)

A full and instructive discussion of this resolution brought out the following points:

(1) Free choice of physicians by patients is restricted.
(2) Patients are assigned to physicians and monies are taken from their salary checks to pay these physicians.
(3) The negotiations for contracts were entered into with the Boards of Trustees of hospitals without the knowledge of the County Medical Societies, The Medical Society of New Jersey, or the Medical Staffs of the hospitals.
(4) The general practitioner is left out of the groups practicing this way.
(5) These groups are in essence closed-panel groups with direct contracts with hospital Boards of Trustees.

The discussion culminated in the following **recommendations**:

(1) That the resolution be adopted.

Adopted

(2) That a copy of the resolution be forwarded to the Council on Legislation so that it may be alerted to the problem.

Adopted

(3) That a copy of the resolution be forwarded to each Hospital Medical Staff in New Jersey so that they may also be alerted to the presence of this situation.

Adopted

7. **Proposed Guides for Physician-Hospital Relationships in New Jersey, Resolution #16** (page 323)

A free, lengthy, and animated discussion was held on the topic concerned in this resolution. It was agreed that the problem should be one of interest to every physician present. It was further agreed that the text of the PROPOSED GUIDES be made a part of the record of this reference committee and be presented to the House of Delegates as follows:

PROPOSED GUIDES FOR PHYSICIAN-HOSPITAL RELATIONSHIPS IN NEW JERSEY

INTRODUCTION

The Medical Society of New Jersey, through its Committee on Physician-Hospital Relationships, sets forth the following principles, together with specific applications of them in the matter of improving the relationship of physicians to hospitals, in the belief that these principles will be in the best interest of the patients whom its members serve. It is hopefully anticipated that the individual hospitals in which our members practice, and the hospitals of the State as a whole, will find the following acceptable.

SECTION I—HOSPITAL MEDICAL STAFF

Members of The Medical Society of New Jersey should expect the hospitals wherein they serve to

grant them the following rights, subject to the approval of the hospital Board of Trustees:

1. The right of the active medical staff, or other broadly-based segment of the medical staff, to elect the officers and chiefs of departments and divisions of the medical staff of the hospital.

2. The right of the active medical staff, or other broadly-based segment of the medical staff, to review and revoke the actions or elections of officers, Executive Committee, or medical staff physicians.

3. The right of the active medical staff, or other broadly-based segment of the medical staff, to formulate and to revise the Bylaws and Rules and Regulations of the medical staff.

SECTION II — RELATION OF PHYSICIAN TO INTERN OR RESIDENT

Physicians shall be zealous in the teaching of the art of medicine to all house officers assigned to them. They shall not directly or indirectly compensate interns or residents for their services, this being an obligation of the hospital; nor will they permit an intern or resident to carry out a procedure or treatment customarily the responsibility of the attending physician without the prior consent of the patient.

SECTION III — MEDICAL STAFF APPOINTMENT

No member of The Medical Society of New Jersey should have his hospital staff appointment revoked or reappointment denied unless the following procedure is substantially followed:

1. The Board of Trustees of the hospital taking any action to revoke a medical staff appointment or to not reappoint a member, either to the medical staff or even to the same rank and privilege as previously held, shall act only after its proposed action has been considered by the medical staff or its representatives and in accordance with any applicable provisions of the Bylaws of the medical staff.

2. Written notice indicating the grounds for the proposed action should be sent to the medical staff member involved as well as to the medical staff or appropriate medical staff body.

3. Such actions aimed at separating a member from the medical staff may be initiated by the medical staff or the governing body, but it must be referred to the proper medical staff committee which will make its report to the medical staff or appropriate medical staff body which, in turn, shall send the committee report together with its recommendations to the governing body.

4. Should the medical staff member involved, or the medical staff, be unwilling to accept the decision of the governing body, a request for a review will made in writing to the administrator of the hospital within 30 days after receipt of written notice of the governing board's action.

5. A committee of equal representation of the medical staff and the governing board (e.g., Joint Conference Committee) shall be formed to review the case and send its recommendation to the governing body with a copy to the medical staff or appropriate medical staff body within 30 days.

6. If the above procedure is not substantially followed, The Medical Society of New Jersey shall lend its good offices to any member so burdened.

Steps should be initiated which will lead to a procedure acceptable jointly to The Medical Society of New Jersey and the New Jersey Hospital Association whereby a joint committee to review such cases might be created and a method of binding arbitration promulgated.

SECTION IV — REMUNERATION OF THE PHYSICIAN BY A HOSPITAL

While The Medical Society of New Jersey considers it improper for any of its members to accept remuneration from a hospital for the direct medical care of a patient from whom the hospital directly or indirectly receives a fee, it recognizes that in certain less direct types of medical care, usually of a consultative nature, such remuneration is customary and is proper if consonant with the principles that follow. The Medical Society of New Jersey endorses the conclusion as set forth in "Guides for Conduct of Physicians in Relationships with Institutions," adopted by the American Medical Association in December 1951, and reaffirmed by its House of Delegates in December 1959, which reads:

> "A physician should not dispose of his professional attainments or services to any hospital, corporation, or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee."

The Medical Society of New Jersey likewise endorses the statement made at the same time:

> "Lest there be any misunderstanding, we state unequivocally that the AMA firmly subscribes to freedom of choice of physicians and free competition among physicians as being prerequisites to optimum medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows of, or abridges, such freedom of choice and such competition."

While the manner of remuneration of a physician by a hospital for professional services may have many acceptable forms, any agreement should

be judged by the degree to which it satisfies the following conditions:

1. The financial arrangement between a hospital and a physician should be placed on a mutually satisfactory basis, but a physician should not dispose of his professional services and attainments to any hospital, lay body, organization, group, or individual, by whatever name called or however organized, under terms or conditions which permit exploitation of the patient, the hospital, or the physician.

2. The medical staff appointments and reappointments of specialists in anesthesiology, pathology, physical medicine, roentgenology, electrocardiography, medical education, pulmonary function evaluation, and other similar integral parts of the practice of medicine should be governed by the same principles as appointments and reappointments in surgery, internal medicine, and other designated fields of medical practice.

3. The employment of a physician in a professional capacity by a hospital should be consonant with the following considerations:

   a. That the hospital recognize "that as diagnostic and treatment services become more complex it is necessary more and more for hospitals to consult with the medical staff on matters relating to hospital physician specialist relationships. This is particularly true: a) regarding the specialist's selection where professional qualifications determine the individual to be selected, b) regarding unresolved problems arising in connection with hospital and physician specialist relationships, including financial problems, and c) regarding charges made for services." (from "Statement on Hospital and Physician Relationships," adopted by the American Hospital Association, 1959)

   b. That the qualifications for the position should be specified and be made available to all interested parties insofar as is possible and practicable.

   c. That the method of appointment to the position be promulgated. This method should be consistent with the statement from the Joint Commission on Accreditation issued in connection with electrocardiography but applicable to all professional situations:

      "The interpretation of electrocardiograms is much like any other work in the hospital. It is a privilege that should be granted to a physician or physicians by the Credentials Committee of the staff, taking into account the applicant's training, qualifications, experience, and demonstrated ability." (page 109, Hospital Accreditation References)

   d. That when vacancies occur or are about to occur the fact should be well advertised to the staff and even outside the institution if desirable. The practice of co-optation, that is the selection of their successors by persons already holding positions in the hospital, should be strongly disapproved.

   e. That the payments for such services should be separated into those for supervisory services and those for personally performed professional services.

   f. That the rate and amount of payment for, and anticipated annual income from, a particular position should be available to the staff.

   g. That the payment on the basis of monthly or yearly salary is proper only for that portion of the physician's services which are supervisory. In any activity wherein the hospital is traditionally compensated on a fee-for-service basis, the physician also should be compensated on a fee-for-service basis for any service he *personally* renders (albeit not necessarily the same fee). Otherwise, the arrangement will violate the principle quoted in the opening paragraph of this section.

   h. That rather than restricting such in-hospital medical services to one or a few doctors in each activity, an attempt be made to permit participation of as many qualified physicians as possible. In any event, the remuneration of any physician from any in-hospital professional activity should never be so great as to give the informed person the impression of exploitation or monopoly. Before this state is reached other physicians on the staff should be invited to participate in the activity.

   i. That the hospital use the term "fee" to describe the remuneration it pays any physician for his services.

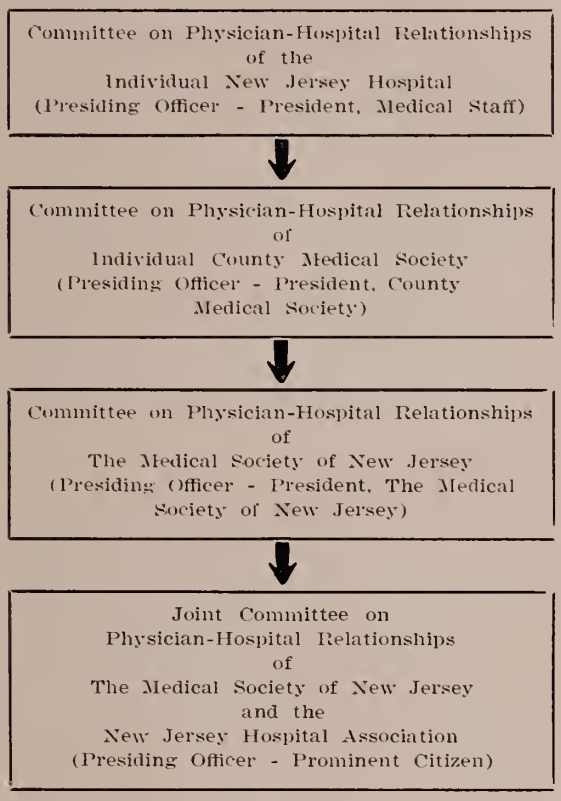
   j. That the chief of a hospital department have access to the financial information regarding his department.

SECTION V — GRIEVANCE PROCEDURES

Any member of a hospital staff who feels that he has a grievance against his hospital shall first attempt to obtain adjustment of this situation within the institution through the joint conference committee of his hospital. Failing in this he shall be free to present his case before the appropriate physician-hospital relationships committee.

The Medical Society of New Jersey shall appoint a continuing committee to act as a board to hear any charge of exploitation or other grievance of a physician-member pertaining to a physician-hospital relationship. If the grievance is not resolved by this board, it is to be passed on to a higher board for final hearing and binding arbitration.

PROCEDURAL CHANNELS PROPOSED BY THE MEDICAL SOCIETY OF NEW JERSEY FOR PROBLEMS ARISING IN PHYSICIAN-HOSPITAL RELATONSHIPS IN NEW JERSEY



It is hoped that the New Jersey Hospital Association will appoint a similar corresponding group at the same level as suggested by the foregoing chart.

SECTION VI — PHYSICIAN-HOSPITAL FINANCIAL ARRANGEMENTS

Resolution adopted by the 1955 House of Delegates of The Medical Society of New Jersey:

Resolved, that we unequivocally condemn the practice of assessing staff physicians, and be it further

Resolved, that we urge each physician voluntarily to contribute to the hospitals of his choice as much as he can donate without hardship, provided that the amount of such contribution is to be determined only by the physician himself; and that no hospital impose any penalties, sanctions or restrictions on any physician by reason of the amount of his donation.

(If the above does not cover "capitation fees," necessary action should be taken by MSNJ and be included as part of this section.)

(End of Proposed Guides)

The reference committee stresses to the House that this is a working version of the Guides for Physician-Hospital Relationships in New Jersey. It further stresses the facts that final drafts are not complete and that the present form of the "Guides" is presented at this time for the information of the physicians of New Jersey, to (1) alert them to the situations that exist in some parts of the state, and (2) solicit their comments and suggestions during the coming weeks to the special subcommittee considering the Guides.

The reference committee makes the following **recommendations** concerning the resolution and the Guides to Physician-Hospital Relationships in New Jersey:

(1) That the subcommittee continue its excellent and time consuming work with the Guides to Physician-Hospital Relationships, and that the committee contact the New Jersey Hospital Association at its earliest convenience to discuss these Guides.

Adopted

(2) That every member of The Medical Society of New Jersey be circulated with a copy of the "Guides" in their present form so that they may acquaint themselves with the contents in order to make pertinent comments and suggestions to the subcommittee.

Adopted

(3) That the subcommittee prepare as soon as possible a final version of the Guides to be presented to the Board of Trustees of The Medical Society of New Jersey for study and review prior to consideration by a subsequent House of Delegates meeting.

Adopted

At this time I would like to commend the Annual Meeting Committee in their planning to have a day intervene between the second and third sessions of the House of Delegates. This is a tremendous help to reference committee chairmen and to the overburdened secretarial staff who must prepare our reports. I trust that this practice will continue throughout the years to come.

Report adopted as a whole.

REFERENCE COMMITTEE "G"

Robert H. Areson, M.D., Chairman

Reference Committee "G" met at 11:00 a.m., May 12, 1963, with all members present—Dr. Blake, Dr. Crane, Dr. Demy, Dr. Lee, and the chairman, Dr. Areson. Several trustees and delegates also were present and made constructive suggestions.

1. **Polio Immunization** (page 271)

The action of the Board of Trustees concerning polio immunization was approved, and is **recommended** for approval by the House.

Adopted

2. **Council on Public Health** (page 301)

The report of the Council on Public Health, which contained no specific recommendations, was approved as submitted, and is **recommended** for approval by the House.

Adopted

3. **Special Committees to the Council on Public Health**

A. **Cancer Control** (page 302)

We **recommend** approval of this report, including its two recommendations which read:

1. That the Special Committee on Cancer Control include in its activities promotion of an expanded cancer detection program that will include all practicing physicians.

2. That the special committee establish liaison with the Medical Advisory Committee of the New Jersey Division, American Cancer Society, to enlarge the scope of an educational program.

Adopted

B. **Child Health** (page 302)

This report is **recommended** for approval, including the special committee's recommendation:

That The Medical Society of New Jersey continue its efforts to revise Section 18:14-17 of the Revised Statutes—Chapter 25 of the Laws of New Jersey of 1955—to enable schools to accept evidence of a physical examination by the family physician in lieu of a mandatory examination by the school physician.

Adopted

C. **Chronically Ill and the Aging** (page 303)

The committee **recommends** that a few points in the "Home Care Program" be amended as follows:

(1) Referrals—All referral of patients to the Home Care Program must **have the approval of a** physician.

This change is recommended due to the fact that experience in existing programs has shown that the initial referral is on a physician basis only in about 20 per cent of the cases.

Adopted

(2) Personnel—The personnel of the Home Care Program will consist of a team under the direction and **supervision** of a medical doctor. The team will include the patient's own physician, **a** coordinating **officer**, and other related personnel (such as a social worker, physical therapist, registered nurse, etc.).

Adopted

Evaluating the needs of the patient is a job for the entire team, **but his medical care must continue to be the sole responsibility of the attending physician.**

Adopted

(3) Cases to be Covered (second paragraph)—The responsibility for developing the procedures to implement and continue the Home Care Program is vested in the entire team, and should provide the following:

1. Coordination by coordinating **officer.**

2. Services of the home care team, such as the patient's physician, the coordinating **officer,** and other related personnel.

These changes are recommended because the committee is of the opinion that the "coordinating officer" need not be a physician. Indeed, it would seem unlikely that a physician should devote himself to the minutia

of "coordination" problems. The physician, however, must remain in overall charge of the home care program team.

Adopted

D. **Conservation of Vision** (page 305)

The reference committee **recommends** approval of the report of this special committee and its recommendations:

1. That the House of Delegates approve the continuation of the Eye Health Screening Program, scheduled for the week of September 23, 1963.

2. That the School Eye Care Program be approved as presented for continued action by the committee next year.

3. That the committee, in the interest of the public welfare at large, continue to investigate the contact lens problem.

Adopted

E. **Conservation of Hearing and Speech** (page 305)

F. **Maternal and Infant Welfare** (page 306)

G. **Mental Health** (page 307)

H. **Rehabilitation** (page 307)

These reports contained no specific recommendations, and were approved as presented. We **recommend** their adoption.

Adopted

Report adopted as a whole.

REFERENCE COMMITTEE "H"

Charles P. Campbell, M.D., Chairman

Reference Committee "H" met on Sunday, May 12, 1963, at 11:00 a.m. and considered each of the items referred to it. All members of the committee were present—Dr. Spirito, Dr. Spillane, Dr. Bowne, Dr. Henriksen, and the chairman. In addition there were six deliberants. The meeting adjourned at 1:10 p.m.

1. **Annual Meeting** (page 274) and its **Subcommittee on Scientific Exhibits** (page 276) and **Scientific Program** (page 276)

The committee **recommends** that these reports be approved as contained in the printed record, including this recommendation:

That the 201st annual meeting be held at Haddon Hall, Atlantic City, Saturday-Wednesday, May 13-17, 1967.

The reference committee commends and applauds the Committee on Annual Meeting and its subcommittees for a job well done.

Adopted

2. **Disaster Medical Care** (page 308)

The committee **recommends** to the House that this report be accepted in its entirety. In this regard, the committee particularly urges the membership to visit the exhibit of the model 200-bed civil defense emergency hospital—E-109.

Adopted

3. **Nominations for Emeritus Membership** (page 284)

The committee approves the nominations for emeritus membership as printed in the annual reports and in the supplemental report, and **recommends** their approval by the House.

Adopted

4. **Honorary Membership** (page 280)

Since there were no nominations for honorary membership, no action need be taken on this report.

No Action

5. **Nursing Education** (page 308)

The committee heard a number of interesting speakers on this subject. This portion of the committee's business consumed the greatest time. The committee **recommends** that this report be accepted, with the following revision: Page 93, paragraph (2): Delete the entire paragraph and substitute:

Nursing schools do not have sufficient funds for expansion. It is obvious that there are public and private funds not fully utilized for the expansion of nursing education. Further investigation and use of these funds are recommended.

Adopted

In approving this report, the reference committee also approves the accompanying recommendations:

(1) That this report be sent to all the organizations and administrators that participated in these conferences so that viewpoints of all can be known.

(2) That The Medical Society ask all interested groups to form a committee to deal with this problem. This group can then coordinate its efforts with the necessary public officials to help speed up the solution.

(3) That The Medical Society of New Jersey petition the Governor to hold a special convention on nurse recruitment, utilizing the above groups, and adding the necessary public officials so planning may be translated into action.

Adopted

The reference committee commends the constructive efforts of the Committee on Nursing Education, and **recommends** to the House of Delegates:

(1) That the report be approved, and
(2) That a permanent Committee on Nursing Education and Recruitment be established.

Adopted

6. **Physicians Placement Service** (page 312)

The committee **recommends** approval of this report, as printed.

Adopted

7. **Traffic Safety** (page 314)

The committee **recommends** that this report be accepted in its entirety.

Adopted

8. **Woman's Auxiliary Advisory** (page 288)

The committee **recommends** that this report be approved.

Adopted

* * *

Your chairman is grateful for, and appreciative of, the efforts and time of his committee, those who participated in the deliberations of the committee, and the chairmen of committees whose reports were considered

Report adopted as a whole.

REPORT OF NOMINATING COMMITTEE AND ELECTION

May 12, 1963

OFFICE	NOMINEE AND COUNTY
President-Elect	Charles H. Calvin, Middlesex County
1st Vice-President	John J. Bedrick, Hudson County
2nd Vice-President	Joseph R. Jehl, Passaic County
Secretary	Marcus H. Greifinger, Essex County
Treasurer	Daniel F. Featherston, Monmouth County

(All elected for a term of 1 year: May 1963 — May 1964)

Trustees:

2nd District	Joseph P. Donnelly, Hudson County
3rd District	Samuel J. Lloyd, Mercer County
4th District	Frank J. Hughes, Camden County
11th Trustee	John F. Kustrup, Mercer County

(All elected for a term of 3 years: May 1963 — May 1966)

OFFICE	NOMINEE AND COUNTY
Judicial Councilors:	
1st District	Thomas S. P. Fitch, Union County
4th District	E. Vernon Davis, Burlington County
(All elected for a term of 3 years: May 1963 — May 1966)	
AMA Delegates:	
	Jesse McCall, Sussex County
	Joseph P. Donnelly, Hudson County
	Isaac N. Patterson, Gloucester County
(All elected for a term of 2 years: January 1964 — December 1965)	
AMA Alternates:	
	Joseph R. Jehl, Passaic County
	Louis S. Wegryn, Union County
	John L. Olpp, Bergen County
(All elected for a term of 2 years: January 1964 — December 1965)	
Delegates and Alternates to Other States:	
New York:	
Delegate	William F. Costello, Morris County
Alternate	G. Ruffin Stamps, Atlantic County
Connecticut:	
Delegate	Lloyd A. Hamilton, Hunterdon County
Alternate	S. Eugene Dalton, Atlantic County
(All elected for a term of 1 year: 1964 Convention)	
Administrative Councils:	
Legislation:	
5th District	John S. Madara, Salem County
6th Member	Winton H. Johnson, Bergen County
Medical Services:	
5th District	Charles B. Norton, Jr., Salem County
6th Member	I. Edward Ornaf, Camden County
Public Health:	
2nd District	Francis R. Meyers, Passaic County
(unexpired term of Samuel C. Yachnin, resigned—1 year: May 1963 — May 1964)	
5th District	Carl J. Records, Cape May County
6th Member	John P. Coughlin, Hudson County
Public Relations:	
2nd District	Francis I. Tomlins, Bergen County
5th District	Josiah C. McCracken, Jr., Atlantic County
(All elected for a term of 3 years: May 1963 — May 1966—except as indicated)	
Standing Committees:	
Annual Meeting	Herschel S. Murphy, Union County
Finance and Budget	Theodore K. Graham, Passaic County
Medical Defense and Insurance	Ernest C. Hillman, Jr., Essex County
Medical Education	Louis F. Albright, Monmouth County
Publication	George B. Sharbaugh, Mercer County
Woman's Auxiliary Advisory	George O. Rowohlt, Bergen County
(All elected for a term of 3 years: May 1963 — May 1966)	

All nominees unanimously elected to the designated offices for the terms indicated.

Open Discussion on Medical-Surgical Plan

Saturday Afternoon Session
May 11, 1963

The discussion on the Medical-Surgical Plan was convened at 4:15 p.m., Nicholas F. Alfano, M.D., President, Medical-Surgical Plan of New Jersey, presiding.

DR. WEGRYN: It is a privilege to introduce Dr. Alfano, president of the Medical-Surgical Plan, who will chair this discussion.

(Applause)

DR. NICHOLAS F. ALFANO: Thank you, Dr. Wegryn. It gives me great pleasure to welcome members of The Medical Society of New Jersey, and guests, to this open discussion on Medical-Surgical Plan—a session which has become a traditional component of this Annual Meeting. We are grateful to the Society for providing, within the framework of organized medicine, the opportunity for frank discussion between the Plan and members of the medical profession. This is as it should be. Blue Shield was created by organized medicine, is linked to organized medicine by indestructible bonds, and serves organized medicine as its own mechanism for voluntary prepayment of medical and surgical costs.

At a dinner two weeks ago, a discussion with several doctors got around to this Annual Meeting and conjecture as to controversial matters which might come up. Turning to me, one of the group said, "I hope you're not going to begin your remarks at the open discussion in Atlantic City by saying 'It gives me great pleasure'"—which I did say a moment ago. He went on to say, "It seems unlikely that anyone would derive pleasure from sitting up there and inviting a barrage of brickbats, to which Dr. Schaaf for many years, and you more recently, have been subjected."

Well, of course we do get some brickbats, and we occasionally get a bouquet, too. But I am completely serious when I say that it gives me great pleasure, as I am sure it did Dr. Schaaf before me, to preside at this session.

Perhaps you wonder why. One reason is that it affords us the opportunity to discuss with you, face to face, some of the things that are on your minds about Medical-Surgical Plan, and some of the things that are on our minds. Such discussion among reasonable and objective thinking men can only be of benefit to all concerned. It helps us to understand better some of your problems that relate to the Plan, and I fervently hope that it helps you to understand some of our problems better, and the reasons for them.

As part of achieving that sort of understanding, I would ask you, for a few minutes today, to change places with us in your imagination and survey the scenery from this side of the fence. I might add that if you are allergic to brickbats, perhaps you should think twice before making the transition.

First, start with the premise that no human being is without fault. No large organization composed of human beings can be without fault. Many of you have felt that the Plan has been at fault, from time to time, in dealings with you involving payment or the scope of a procedure, the eligibility of a service performed, and kindred matters. In some of those items, we *have* been at fault. When this is evident, as some of you know, we do our best to admit the error and make swift retribution.

Now, if you are comfortably seated—or perhaps I should say not too comfortably seated—on the Plan's side of the fence, you will become aware of one thing immediately; that is, that such problems with individual physicians constitute only one of the pressures to which the Plan is constantly subjected. There are other pressures, other problems and other considerations—all of which interact on one another, including your problems as physicians.

One of these additional pressures comes from subscribers. If you have examined one of our Subscription Contracts carefully you know that it states, and I quote, "The Plan is operated for the benefit of its Subscribers." Now, there may not be many subscribers who could quote you the contract provisions on eligible and ineligible services or service benefits, but most of them apparently have read that the Plan is operated for their benefit. Some interpret this quite broadly. The most common manifestation is a letter that says, in effect, "I have been paying my premium for ten years and never had a claim before, so I think you should allow a higher payment on this one." Or a letter contending that we should declare a particular ineligible service to be

eligible, which the writer obviously feels would be to his benefit.

We must protect the interests of the subscriber just as zealously as we do those of the Participating Physician. This protection often must take the form of denying an exception to an individual because, in equity, all must be treated alike. An exception granted to one would mean that the same exception must then be granted to all. Since the Plan's rate structure is based upon the eligible services covered and the eligible fees established for those services, any broadening in either area, services or fees, would cause a hole in the dike that soon would be followed by a flood that would engulf us, financially. Either the Plan would be destroyed, or it would have to price itself out of the market with rates that could support the increased services and/or fees, and thus defeat the very purpose of this Plan. Those who would need it most would be unable to afford it, and only the most affluent would then be able to purchase the type contract that would be so broad in its coverage and services.

So while we sometimes must say "no" to physicians, we just as frequently must say "no" to one subscriber, in the interest of all subscribers.

Another important force bears upon the operations of the Plan: regulatory control by the Department of Banking and Insurance. Indeed there is even now under consideration in Trenton legislation which would greatly increase the control of the Commissioner of Banking and Insurance over the Plan's operations. We believe this is unnecessary. The Commissioner's authority is already very broad, and the Plan must operate within the confines of its enabling act under his constant scrutiny.

Proposed legislation represents another area of pressure on the Plan. Certain bills which have been introduced in the current Legislature would be of considerable benefit to Medical-Surgical Plan and Hospital Service Plan, if they were enacted. I refer to those bills which would allow both Plans to experience-rate, to enter into national accounts, and to issue master contracts. Medical-Surgical Plan and Hospital Service Plan in New Jersey *are the only Blue Shield and Blue Cross Plans in the country currently prohibited from doing these things.* The Legislative Commission which studied the problem of health care costs recommended these measures. We would like to see them passed.

Pressure against passage of these beneficial measures comes, principally, from the area of commercial insurance. Apparently some of the commercial companies feel that the Blue Plans might provide more competition if the Plans were granted some of the prerogatives of their commercial neighbors. The other side of the legislative coin is made up of some bills that we believe would be harmful to the Plan, like the one which would increase the Commissioner's authority. The area of pressure here is between the Plan and those legislators who would like to see more government control in medicine.

Perhaps at this point you are thinking, "You don't need to tell me all your problems; I've got troubles of my own." What I am suggesting, in effect, is that Plan problems are also your problems, because they bear directly upon the achievement of our common aim: To make available adequate personal and sympathetic medical care at the lowest cost compatible with efficient service.

Because we do share a common goal, and because the Plan owes its origin to The Medical Society of New Jersey, and its continued existence to the Society and the Plan's Participating Physicians it is our conviction that problems between the Plan and members of organized medicine should be settled within the framework of organized medicine, of which this forum is a vital part. We believe that dissatisfaction with policies or procedures of the Plan, on the part of any individual physician, should be aired here, or through other channels within organized medicine, and not to the public press through publication in the *Bulletin* of a County Society.

Repeated attacks upon the Plan have been made in recent months in a *County Society Bulletin*. Two of these articles speedily found their way into the public press, creating a situation in which two members of organized medicine, holding official positions in a County Medical Society, were shown to the public as quarreling with an arm of organized medicine. The situation was not improved by numerous distortions of fact in the published statements of the individuals, neither of whom, incidentally, is a Participating Physician with the Plan.

We have specifically invited the two physicians in question to attend this session and state their grievances in person, through a mechanism provided by The Medical Society of New Jersey. They will be given the opportunity to do so shortly. Meanwhile, since their comments have become a matter of public record in the press, we are going to demonstrate to everyone here that a number of the published statements were not factual.

I am going to ask Doctor Joseph P. Donnelly, Chairman of the Public Relations Committee of the Plan's Board of Trustees, to deal with some of the misstatements quoted in the April 5, 1963 issue of the *Bergen Record*. Doctor Donnelly.

(Applause)

Dr. Joseph P. Donnelly: Thank you, Dr. Alfano. I feel that as members of this House you are not only representing all the members of The Medical Society of New Jersey but you also are representing the 6700 Participating Members of the Medical-Surgical Plan.

You know, in past years this procedure which I am going to do now with the aid of Dr. Alfano, had been taken on by Dr. Schaaf. Today he was given a fiftieth year diploma. He decided that for once he would take the day off, sit back and take a look from the other side of the fence. So I don't know, wisely or not, but all I can say is that it looks like the Medical-Surgical Plan decided to give you the fatted calf this afternoon instead of Dr. Schaaf. So I'm ready to be burned. And I must say this, I thank you, all the 6700 Participating Physicians who have made Medical-Surgical Plan what it is.

In the last twenty years there has been a great demand for national health insurance. The one bulwark which has stood up is the voluntary plans of which the Plan in New Jersey is one we can be justly proud. We are still here discussing *private* fees, *private* consultations, *private* surgical practice, *private* medical practice; instead of discussing, as they are in many countries of the world, how many people you should have in your panel; where you are going to practice next year; and how many years you are going to have to wait before the national health plan moves you up into a surgical apprenticeship. So that we are still here today because of the efforts, I think, of the 6700 Participating Physicians in New Jersey. And before I start, I wish to say to you my personal thanks.

A running campaign of criticism of the Medical-Surgical Plan has been conducted in the *Bulletin of the Bergen County Medical Society* since last December. Two of the articles were reprinted under prominent headlines in the *Bergen Evening Record*.

The articles in question were expressions of the view of two individual physicians. They, incidentally, were replete with many misrepresentations. Their publication in the official organ of a County Society certainly implied, to the uninformed, that these were official views of the Society itself. It is the feeling of the Plan—and, we understand, of many members of the Bergen County Society—that these two physicians abused their positions by making use of a Society publication to state personal grievances.

Even if the articles had conveyed the official sentiments of the Society, we feel that there are more appropriate channels for airing dissatisfaction with the Plan, than exposing them to the public press. Newspapers are often not reluctant to publicize rifts within organized medicine. One of those channels is this forum, provided by The Medical Society of New Jersey for just such matters, and I would say that here and now we welcome your criticism. Another is the hearing room of Reference Committee "C", where you will be given another opportunity. We invited both these doctors to attend this Open Discussion, as well as the hearing of Reference Committee "C", to state their grievances in person and under circumstances that afford the Plan a suitable opportunity to reply.

Up to this time, statements made in the editorial appearing in last month's *Bergen County Society Bulletin* and quoted in the *Bergen Evening Record* of April 5, 1963, have gone unchallenged. The misrepresentations made there should be corrected under these auspices at this meeting.

I will now direct my remarks to the article in question, specifically to the newspaper version, which was seen by some 120,000 persons.

The headline reads, and I quote, "Bergen Doctor Raps Blue Shield's Scope." And the sub-head, again quoting, "Medical Society's Editor Says Benefits Are Pictured Misleadingly." In addition to charging that Medical-Surgical Plan misrepresents its service benefits coverage, the criticisms deal generally with dissatisfaction over fees—on the part of a physician who does not see fit to support the Plan's service to the community by being a Participating Physician.

It is stated several times, in different ways, that Blue Shield fees are not at the level of normal charges for services at the present time. Some of the actual quotations in the paper read as follows:

"The level of Blue Shield payments does not equal enrollment charges for services at the present time.

"The Plan must make a realistic revision of its fee schedule and bring them to normally accepted levels of 1963.

"Blue Shield wanted to pay the full cost of illness but wanted to do it on a fee schedule far below the usual charges in the community.

"Blue Shield must reformulate their poli-

cies to meet the actual costs of 1963."

These are the quotes which appeard in the *Bergen County Record*.

Now let us examine the facts. In February 1962, *Medical Economics* published the results of a nationwide survey to determine the "going rate" for medical and surgical services in various sections of the country. The "going rate" is defined by the magazine as, quote, "The specific fee that a majority of self-employed physicians in a specific region and a specific field of practice do not exceed."

We will compare these "going rates" for those services as determined by the *Medical Economics* survey, in which Medical-Surgical had no part. While the survey was published a little over a year ago, it seems unlikely that the "going rates" have increased to an appreciable extent since then. Perhaps, since the *Bulletin's* Editor specializes in obstetrics, it would be appropriate to make our first comparisons in that field.

(Chart displayed)

This is the "going rate" for the Middle Atlantic States as assembled by *Medical Economics*. For complete obstetrical care for a general practitioner the going rate is $125. The fee by Medical-Surgical Plan is $150. For the specialist the complete care fee is $175; and $150 for Medical-Surgical Plan. For cesarian section $250 is the going rate, and $250 is paid by Medical-Surgical Plan. For a cesarian section referred by another doctor, it's $200 and $200.

So only in the field of the specialist here is there any discrepancy between what Medical-Surgical pays and what the going rate is for the overall picture in the Middle Atlantic States. And as you know, gentlemen, the Medical-Surgical Plan cannot make any distinction. Every licensed M.D. in New Jersey has the right to practice medicine. Legally we cannot make any distinction at all between specialists and general practitioners or non-specialists.

(Second chart presented here)

Note that the Plan fees are exactly equal to the going rates in six of eight instances.

The other quote was "Though some small attempts have been made to give non-surgical physicians equal treatment with the surgeons, little progress has been made in the treatment of medical fees, not surgical fees."

We will now show you what has been done as far as surgical fees are concerned. The first hospital visit (and this is compared with the standard fees by *Medical Economics*) the going rate by their survey the first day is $8. Medical-Surgical Plan pays $10 for the first day. If it is a critical case, a patient with a coronary, diabetic coma or one of the real medical emergencies, Medical-Surgical will pay $25. This is the same as far as the internist is concerned. The going rate is $10; Medical-Surgical pays $10 or $25 if it is a serious case.

Subsequent visits after the first day, the going rate outside is $5; Medical-Surgical pays $7 a day for the first week, then $6, and then $5 for the last week.

And if it's critical care, they get $20 for the second day, $15 and then $7: $6 and $5. The same down here for the internist. There's very little difference.

The 21 visits for the general practitioner, the going rate for 21 days of hospital care would be $108. Medical-Surgical now pays $129; and if it's a patient critically ill with a coronary or something like that, we pay $165 for this medical care.

The same for the internist down there. While the going rate here is $150 for that type of care, Medical-Surgical pays $129 or $165 if it's critical care.

The hospital consultation of the internist, the going rate is $25; Medical-Surgical pays $15; but if it's a critical case, we again pay $25.

So I think after looking at those figures you will see that Medical-Surgical Plan is not so far out of what the going rate is in the Middle Atlantic States.

It is said frequently that this plan is strictly for the surgeons; and some surgeons say that we are not up to paying what they would if they didn't have Medical-Surgical Plan.

(Third chart displayed here)

As you see here, the going rate from the *Medical Economics* survey is $150 for an appendectomy; Medical-Surgical Plan pays $175. For cholecystectomy, $250 is going rate; we pay $225. For excision of a breast tumor, the going rate is $75; Medical-Surgical Plan pays $60. For gastrectomy it's $350 and $300; hemorrhoidectomy, $125 and $100; herniorrhaphy $150 and $150; radical mastectomy $300 to $250; and down here a thyroidectomy, $250 to $225.

Some surgical fees are a little bit lower; but most of them are pretty much on the average of what the going rate is; and I don't think that after looking at that anybody can say, as has been said, that everybody has forgotten about the medical man and this is a surgeon's

plan. At the present time I think only four out of the 22 members on the Board are surgeons, and there are six internists.

(Fourth chart displayed here)

There is also quoted in the *Bergen Evening Record* this statement: "The Plan must cease giving the impression to everyone else, other than very low income groups, that they will be covered for all their medical and surgical expenses."

The charge was that the Plan said in its advertisements and in its contracts that they paid for everything. We show you here the subscription contract. This is the list of the participating physicians. This is the service report. And in all this literature which is put out by the Plan it definitely states that these service benefits apply and apply only to the individual with an income of less than $5000 or to a family with an income of less than $7200. So that this is what we put out, this is what has been stated, and I don't think you can say the Medical-Surgical Plan had misrepresented what it's going to do.

These are the published statements on service benefits. These are the subscribers' literature, the little things that explain it to them and all the things, the income limitations on it are definitely stated and they also give them a list of participating physicians and tell them very definitely that if they are not a participating physician they are not covered by service benefits and the doctor is free to charge them anything else.

If you realize the patient has Medical-Surgical Plan, you can collect a hundred per cent of your fees. If you take $150 for obstetrics, that, although this goes up to $7500, it averages out. The people covered by Medical-Surgical Plan benefits have an average income somewhere around between $6000 and $6500; and an average of 2.2 children. This is a family of four or five getting by on $6500 a year. Say they live near you, and I think that under those circumstances if you know this is a fee that you are going to collect on all the patients covered by Medical-Surgical, that these are very reasonable fees.

Consider the Federal employee program and also the State employee program. Again the income limitations are definitely stated as to the participating and the non-participating physician.

Here is a newspaper advertisement which, among other places, appeared in the *Bergen Evening Record*. It definitely states that the people under $5000, single, or under $7500, family, are the only ones covered by service benefits and only if they go to a participating physician. So it is definitely explained in the *Bergen Evening Record* the limitations of this contract. But it would seem that the two doctors who protested so vigorously read only the *Bergen Evening Record* on the nights when their own names appear in the headlines.

Another quote is this: "The present desire of the Plan to buy 1963 medicine at 1945 prices cannot but fail. It is impossible to buy $10 worth of services for $5".

In other words, according to them, we are still back in 1945. The Plan hasn't done anything to change the things through all these years; but these are the facts.

In 1945 we were getting $50 for a normal delivery and glad to get it. They are now paying $150 for the same service. It was $100 for cesarian section in 1945; and the Plan increased it to $250.

Now, you'll tell me there is one gimmick in there, and there is. It now includes prenatal care, and this is so. But I would also take the opportunity to say that this was no fault of the Plan; this was the way the Banking Commissioner read the contract. The contract was written that they would pay for maternity services both in and outside the hospital, meaning that they would pay for a delivery that took place at home. The legal ruling was that maternity services also included prenatal care. There is nothing we can do with the Banking Commissioner to separate this from the usual maternity fee.

However, from 1945 to 1963 there's been an increase from $50 to $150, and from $100 to $250 as far as fees are concerned. So we are not giving you the same in 1945 as you get in 1963.

This is medical care fees by the Medical-Surgical Plan: $5 in 1945 for ordinary hospital visit; $10 in 1963 for the first visit. For the total of 21 days in 1945 the doctor was paid $65; and in 1963, $129—a hundred per cent increase as far as that's concerned.

This is for critical medical care which we had nothing to do with. There was no separation in 1945. The patient with a bad coronary, the patient in diabetic coma, the patient with a massive cerebral hemorrhage. In 1945 you were paid $5 a day; in 1963 the first day in the critical case you are paid $25. In 1945 the 21 days on a patient critically ill, you were paid $65; in 1963, $165. These are not the same fees they paid in 1945.

In emergency cases there was no fee for that in those days. Now they are paid $10 for the first day.

The fee for medical consultations in 1945

was $10; in 1963 it went up to $15; and for critical cases it went from $10 to $25.

How about medical care for Senior Citizens? This is in the Senior Citizens' conract. In 1945 the fee for the first day was $5. The first day here in 1963 is $10. This is medical care. For 21 days the most you could collect in 1945 was $65; now these older people are covered for a total of 70 days, and they need that much medical care, so a doctor can collect $245.

Now this, mind you, is for the widow down the street whose total income is less than $2500 a year. So you will be paid 10 per cent of what would be her income for the year. Now, that's no widow's mite. If the patient didn't have Medical-Surgical Plan or didn't have a Senior Citizen's contract, few could collect that kind of fee. On the other hand, if she is critically ill with a diabetic coma, the thing goes up to $300 for the 70 days' treatment, which I think is a reasonable fee for anybody in that income bracket. You would collect it in very few cases if they didn't have the Medical-Surgical Plan.

These are fees for five common surgical procedures. In 1945, $150 for a gastrectomy; in 1963, $350. Appendectomy in 1945, $100; in 1963, $175. In 1945 for herniorrhaphy, $75; in 1963, $150. The same for radical prostectomy, in 1945, $100 and in 1963, $275.

Fees have not stood still. They have gone up steadily during these years.

The only thing anybody could collect for anesthesia in 1945 was $10! Now the fee is 20 per cent of the surgical fee and the maximum on it is $70. So there's been a marked increase in anesthesia fee and, of course, this is a major actuarial component as far as the Plan is concerned.

Now the other quote: "The level of Blue Shield payments does not equal the normal charges for services at the present time. This has led to misunderstanding because the patients felt that doctors were over-charging if their fees were in excess of the Blue Shield allowances."

This is the old complaint that Blue Shield fees keeps doctors' fees down even though they are non-participating physicians. These non-participating physicians are objecting to Blue Shield but they don't object to what the Aetna pays. They treat us as an indemnity insurance company. They don't object to what the Aetna pays or what the Prudential pays, but they do object to what the Medical-Surgical pays, even though they are not participating physicians in the Plan and treat it as an indemnity contract.

You might wonder why Blue Shield fees are of concern to non-participating physicians. They are at liberty to charge subscribers whatever they see fit. I think you have the answer here.

The implication, of course, is that patients misunderstand physicians' fees because Blue Shield fees are so much lower than the going rates; so they tell us. I think we have conclusively demonstrated here today that this is not so, and suggest that in cases where there is a large discrepancy between the Blue Shield fee and the physician's charges, the reason for the patient's misunderstanding does not lie with Blue Shield. The fault, my dear non-participating physicians, is with your own fees and not with Blue Shield.

Thank you very much.

(Applause)

DR. REICH: My name is Samuel Reich. I am President of the Bergen County Medical Society. I am the one who started this whole business. I'm not guilty of any of these statements which you have quoted, which were made by the Editor of the *Record*. And I'm not here to defend him. I wish he could come, because I got out of a sick bed to talk with you and I will have to give you a few facts to contradict the remarks of an obstetrician. I didn't state one word in my contentions, nor did he, that the obstetricians weren't paid. They are very well paid.

When I did obstetrics in my general practice days, I charged $35 for prenatal care and delivery. I got deadbeat on 60 per cent of what I did, so my standard pay in those days was probably $20. I have no quarrel with you as far as your payment of obstetricians goes. Also you are doing wonderfully well for the surgeons. I so maintain in all my remarks in my initial editorial because they feel that if there were any adjustments that they would be scaled down a good deal in order to make up for what the medical man should have.

I did not publish this in the *Record* and I do not judge my remarks by whether the *Record* will give me credit. You don't know newspapers if you think you can buy space by either the nature or the quality of your remarks.

My remarks were made as President of the Bergen County Medical Society on the editorial page of our *Bulletin*. They were meant only for medical circles. Nobody was more surprised than I at being quoted in the paper. I was quoted because of its literary quality, sir, if you saw it on the editorial page, and not because of what I said. And perhaps I

made one remark there that tickled them because I thought that what Blue Shield was to the surgeon was manna from Heaven. Now, certainly this is not the kind of criticism I am sure you mean to pick up.

Am I misinformed when I say that non-surgical specialists are paid non-realistic fees? Your very figures here by comparison would indicate that. So a medical consultant gets $25 for a long and dreary case. Why, it took the surgeon a lot less time to do his obstetrics for $250. I'm sure, therefore, that even the $25 that you have raised that to since my quarrel with you started. I was a member of Blue Shield, not Blue Cross. I was a member of Blue Shield and I succumbed to Dr. Alfano's persuasion to stay for a while longer with the hope that something would be done about it. Nothing was done, and I then resigned. I don't know why you want to discriminate against the non-participating doctors because they are potential or have been members of your Plan. In Bergen County, more surgeons do not belong than do.

I have not complained about the surgical specialists that you have put your emphasis on in those beautiful charts. I wonder how long it took to prepare them and at what cost to the Plan.

You talk of how well you now pay for the medical service. I'm not pleading for the general practitioner. I don't want to alienate my general practitioners by saying this is the day, now, of the general practitioner. I'm talking about the medical specialist. I'm talking about the medical specialist who didn't want to practice medicine in his office. He wanted to do a consultation type of work. You have driven him out of the consultation work into his office to do a glorified type of general practice.

I don't see coronaries. I have tried to be loyal to the men who might be potential feeders to me, by not making house calls. When my anginas occlude, they don't call me; they call the man around the corner. I lose my coronaries. I don't ever see an acute coronary except in consultation. So what there is for a medical consultant is not the care of a coronary. That's the GP's job. He keeps it jealously.

What I want to see is a case in consultation at a reasonable fee. And he says, "Doctor, keep your eye on this case." What does keeping your eye on a case mean? Going in each day at no extra fee. And suppose the urologist had been to see the case before you got in? You get nothing. These are the complaints I have had, gentlemen, and I think they should be given consideration.

Now, again I say the *Bulletin* in which I published is not a newspaper and I'm not responsible for its being quoted. We are not oriented to the newspaper. That newspaper is sold only in Bergen County and we wanted to reach your ears and not the ears of the people in Bergen County.

I suppose your term is—I've heard it quoted—like payment for like services, so the specialist isn't worth any more than a general practitioner who does the same service. I suppose the corrolary in the surgical field is that the second-rate surgeon or third-rate doctor would collect the same fee as a professor of surgery who sees a case in one of your elegant hospitals. That's an injustice and something ought to be done about that, too.

Inferentially Dr. Alfano did intimate that there are such things as specialists because he told me (at least in his letter to me or in his answer to the paper that he wrote directly to the paper). I did not get an answer from him. That did go directly to the paper; mine did not. He indicated that a certain percentage of medical specialists do belong to the Plan, so he is defining what a medical specialist is. If you can define them, then I think you ought to treat them the same way.

I didn't expect to be up on my feet, but this is as much as I can say to defend myself. I wish my colleague were here to defend himself because most of your case has been stated against him.

(Applause)

Dr. Alfano: Thank you, Dr. Reich. We certainly appreciate your coming here today so that we can discuss this between us.

From what I gather, your chief complaint and chief concern as to the operations of the Plan is that there is no distinction made by the Plan in its treatment or in its payments for services rendered by physicians; that is, the payment by the Plan applied whether the doctor is an exceptionally qualified man or whether he is a recent graduate or one just out of internship. That, Dr. Reich, is not our fault. First of all, under the law we are not permitted to make any distinction in the physician who renders a service. The law simply states that the Plan will make payment for services rendered by a fully licensed physician.

Dr. Reich: I'm not quarreling with you or the Plan; I'm quarreling with the law. I thought you were on my side to change the law. I'm not finding fault with you people; I'm finding fault with the law. Please let us do something with the law.

DR. DONNELLY: When you wrote the editorial in the *Bergen County Bulletin* you should have quarreled with the law and not with the Blue Shield Plan.

DR. REICH: You didn't read my editorial.

DR. DONNELLY: Yes, I did, sir.

DR. REICH: If you read my editorials, and there were two of them—(and I hope to have others)—you will find they were *general* remarks, more to tickle our men rather than start a serious rumor. But I should like to see the law modified so it will be equitable to all of us.

DR. ALFANO: The Medical Society itself some years ago attempted to develop criteria to distinguish a fully qualified consultant from a general practitioner. A special committee was appointed for this task. After two years, it was given up by The Medical Society because it wasn't possible to make such distinctions. In most plans in the country, payments are equal, regardless of the specific or the particular qualifications of the physician.

DR. REICH: Criteria can be assembled better now than they could twenty years ago. The criteria exist and you take advantage of them in defining a surgeon, except you don't do the defining. You have an agent to do it. You have the hospitals to do it. The hospitals have defined the surgeon for you. If you want something in which we have our fingers to define, we can do it. The means are these and it can be done for every branch of medicine. Make the criteria little, make them strict, but you have criteria.

DR. ALFANO: I'm glad you said that, Dr. Reich, and not I. We think that such can be developed. Medical staffs can, if they wish to, submit to us a list of names of the consultants who, they feel, should receive the payments for consultations. I don't know of any such procedure under study in any hospital. I think you'd have to await a counter-argument from the general practitioners.

DR. ROBERT BRILL (Passaic): About four years ago was the first time that a rider was presented which would enable payment of a hundred dollars for x-ray services. I'm not a radiologist; I'm a pathologist. At that time we felt very strongly that inasmuch as this was a fee which was for *medical* service, it should be paid to a man who is best qualified for this. We tried to support the radiologists so that these payments would go not only to the radiologists but to those who in their specialty practices routinely used x-rays—men such as internists, urologists, orthopedists, chest surgeons and the rest. And at that time, this House of Delegates roundly spanked the radiologists and those who backed them and said any doctor can read any x-ray. I disagreed with this wholeheartedly. That action of the House of Delegates was not in the best interests of the best medical care for the patients in New Jersey.

Dr. Reich, you can see that we still have a long way to go. The men who spend the time and the effort and the interest to specialize are entitled to higher fees; but the majority of the members of the House of Delegates of The Medical Society of New Jersey saw fit not to go along with this. So until the House of Delegates of The Medical Society of New Jersey changes its position, I do not see how we can blame Blue Shield for inequities which certainly exist.

So long as fees are paid to the G.P. who admits a patient in the hospital for every day's visits, I cannot see why this G.P. would turn over the patient to any internist unless he felt that he could not do as good a job in handling that case. So then it becomes a matter of conscience. And if this man is a conscientious physician, in some cases certainly he ought to say, "I'd like you to take over this case and I'll withdraw from it." But this is not again a criticism which should be levelled at Blue Shield.

(Applause)

DR. ALFANO: I think a lot of this misunderstanding might be obviated if we were to accept the fact that Blue Shield does not set the pattern of medical practice. That is done by the profession. We simply follow; we adjust our policies, our procedures and our payments to what the medical profession establishes as acceptable procedures. For example, here just recently cardiac surgery was done more and more; it has become an accepted procedure. Blue Shield amended its schedule to include additional payments for open heart surgery, which consist of a team of physicians. Blue Shield has accommodated its schedule to pay for a team of physicians—something that we have never done in the past insofar as any type of surgery is concerned. Whatever the trend of medicine is, we attempt to follow.

Right now we are grappling, we are studying payments for gastric freeze and gastric cooling. It's something new. One of our committees is studying this. They are collecting information from other Blue Shield Plans. We try to follow what is new in medical practice. We don't set the standards for the medical profession to follow. It's just the opposite of

that. We follow what the medical profession does.

Dr. Reich: You have done a wonderful job in surgery. I counted the number of pages devoted to surgery in one of your bulletins: it was 68 pages. It's two pages to medicine; 68 pages to surgery.

Dr. Alfano: Dr. Reich, I think that you will admit that there *have been* advances in payments for medical care. Payments by Blue Shield for medical care apply to coverage for simply 21 days of medical care. Beyond that the participating physician is free to charge despite his agreement with the Plan. Our coverage is a limited payment for a limited time. We do not expect any physician to accept our payment for 21 days if his services are rendered for a coronary for five or six weeks or longer. There *is* a limitation in our payment for medical care. For that limited period, as the charts indicate, our schedule has made an attempt to keep up with the going rates in this area. And again I must speak on averages. The average payments by the Plan, we feel, our fair and adequate.

Dr. Donnelly: There are more pages to surgical fees because there are more specific surgical procedures. The medical fees which Dr. Reich finds so objectionable were not made by me as an obstetrician or not made by Dr. Sprague as a surgeon but by a group of certified board *internists* who came and gave their thoughts to the fee committee. This came from the internists. That's the only thing we have to go by. That's what we did go by, and if they were satisfied we thought it was a good fee.

Dr. Reich: If geographic area is recognized in the law, then may I say that Bergen County in the days when you set these things up was represented by two men. One was an obstetrician on your Board and is still today; and a medical man in our area, who at that time was a general practitioner and was no internist of any sort whatsoever. I don't think there was an internist that represented Bergen County in those days.

Dr. Donnelly: I don't know that $6200 goes any farther in Bergen County than it does in Gloucester. I mean this is the same basis, the same income level in Bergen County or any place else. These are the people that you are taking care of.

Dr. Alfano: If I may make one other point, Dr. Reich. I believe that when Dr. Donnelly made reference to internists, this was an official body of the State. They were representatives of the Internists Society of New Jersey, who requested conferences with the Plan to consider and review certain additional payments and procedures.

The Plan has always welcomed specialty groups for any area to review fees and to discuss matters of mutual concern, and I think that many of you here will agree that the Plan hasn't ever refused any group a conference to discuss the schedule, its policies and procedures.

Dr. Reich: I'm not ready to criticize the birth of the Plan and the congenital defects of the Plan. I'd like to point out to you an injustice to the non-medical specialist: the pathologist, the radiologist, the pediatrician, the neurologist and the internist. They would like to practice their kind of medicine and not have direct contact with the patient so they can make these good fees that you say you now pay: men who, when they do their work, do not get comparable compensation. I speak for at least fifty men in Bergen County.

Dr. Alfano: The overall figure doesn't support that statement, Dr. Reich. There are over 6700 participating physicians in the State. Surely they can't all be wrong. They must be satisfied because there is nothing in this world that holds them to the agreement. They are free to resign any time, and yet the majority of physicians within the State continue to support the Plan.

Dr. Reich: When I was a child, when you brought a professor in or called a specialist from New York City who had a double name, he used to get a $150 fee. I wonder what their compensation is today when Blue Shield will pay $15 and he splits a bill for the balance of $135. Something is deteriorating the fee of those days.

Dr. Alfano: This problem of fees for consultations, Dr. Reich, is not a new one. The Plan recognized several years ago that consultation fees in some instances may be low. In consultations with qualified internists the Plan was advised that it might be better to delete consultations as eligible services and leave payment up to the physician who would be a participating physician. Since consultation would then no longer be an eligible service, he was free to arrange whatever payment he wished with his patient without the Plan entering into it. We had many objections to the deletion of consultations. A group of internists from South Jersey wanted the consultation continued in the Plan. The compromise then was that we would have one consultation, whereas previously in the previous contract we would pay for two consultations; and any additional consultations would not be payable but would be included in the two payments for

the eligible consultations. So the Plan continued to pay for the single consultation as our current contract provides. But we wanted to delete them completely. There was objection by the House of Delegates; there was objection by an internist group, and there was objection by the Department of Banking and Insurance. It was a deletion of a benefit that the people had had previously.

DR. SCHAAF: This has been a most interesting discussion but it's really out of place. For several years, the Medical-Surgical Plan of New Jersey made an effort to distinguish between grades of medical service: the specialist, compared to the general practitioner. We repeatedly petitioned The Medical Society of New Jersey to provide us with an acceptable list of specialists in the various fields to whom, perhaps, the Plan might have been able to pay a differential fee. That procedure obtains in a number of Blue Shield Plans but not in New Jersey. A great deal of time and attention was devoted to it by the Board of Trustees and by the House of Delegates from time to time. The committees that considered it and the Board of Trustees came to the conclusion it was not feasible to develop an acceptable list of specialists. Here is why.

One of the finest otologists that New Jersey ever had, now deceased, was not a Fellow of the College of Surgeons; he was not a Society of Surgeons member; he was not certified by the Board of Otology—and yet if I had my mastoid done, he was the man who would do it. One of the best urologists in the State is not a Fellow of the College of Surgeons; he is not certified by the Board of Urology; he is not a Society of Surgeons member—and yet I will be very happy—I hope I don't need his services—but I'll be glad to avail myself of them if I needed them.

Under the law I can declare myself to be a specialist in anything. It is up to the individual hospital whether they are going to let me practice as a specialist in that field or whether it isn't. There is no practical way that The Medical Society of New Jersey can develop a group of specialists to whom the Medical-Surgical Plan would be properly paying additional fees.

I am sympathetic to Dr. Reich's point of view. I have no criticism of him or what he said or what was published as having been said by him. I understand his point of view but the discussion should take place with The Medical Society of New Jersey and not with the Board of the Medical-Surgical Plan. Every member of the Board is cognizant of the time and effort we devoted in past years to developing a differential between grades of medical-surgical service. It just can't be done unless we have the authority of The Medical Society of New Jersey on which to base it. We are an insurance company. We are legally and morally unable to differentiate between grades of medical service.

(Applause)

DR. DONNELLY: I personally wish to thank Dr. Reich for coming here today. This is where the thing should be discussed. All of us at times have differences of opinion. It is much safer, however, if it is reviewed in the framework of organized medicine. And I'm sure, Dr. Reich, that when you wrote that article for the *Bergen County Bulletin* that you did not write it for the *Bergen Evening Record;* but these things always have a way of finding themselves down the street if somebody in the audience gives some friend of theirs a hot tip and there we go and it's all out in the public. I think you will agree with us on this much today: that as far as the *Bergen Evening Record* story is concerned, for which you, sir, were in no way responsible, it did not do any good to organized medicine. In the future in all these things, in hospital bulletions or statements by doctors in their own county bulletins, we should guard against undue lay publicity. This is the type of live news story that the press likes to jump upon and make great mountains out of small ones.

DR. REICH: Doctor, if you are going to gag the *Bulletin of the Bergen County Medical Society*, you might as well gag the meetings of The Medical Society of New Jersey.

In 1955, at the instance of Dr. Alexander, I presented a paper here on the hazards of antibiotics. It was one of the early papers on the hazards of antibiotics. My remarks were syndicated all over the country. The doctors said, it was alleged, that if you put your arm up for a shot, you are asking the doctor to kill you. Am I responsible for that? Would you close the doors of deliberations of this organization because it might get in the paper? The analogy is strict there. I feel the *Bulletin of the Bergen County Medical Society* is among us.

DR. IRVING KLOMPUS: I have been Chairman of the Council on Medical Services for a few years.

In answer to Dr. Reich's fear of being gagged, and it's a real one, may I suggest that he have his entire *Bergen County Bulletin* copyrighted, at very small cost. Then they can prohibit the reproduction or use of any of the articles there without specific permis-

sion. This rather unhappy result might have been obviated by a very simple thing of that nature.

Our subcommittee studied the entire business of accreditation of surgeons and other specialists, about three years ago. The criteria are absolutely meaningless. It's as ridiculous as a person calling himself a specialist. As Dr. Schaaf said, this is absolutely legal. To let the hospitals, on the other hand, determine who is and isn't a specialist, is also opening the door to a control that perhaps we had better do within.

(Applause)

Dr. Alexander: My name is Stewart Alexander of Bergen County. A statement has to be made when an inequity is believed to exist. These feelings were prevalent in Bergen County as they are in other parts of the State. This has, over the years, repeatedly been said. I don't point the finger exclusively at the MSPNJ because it's true in all of the insurance policies. But they take their lead from those insurance programs which were believed to have been set up by the doctors. The point remains, however, that there is a total inequity in the distribution of the monetary value or the fee returned for various branches of surgery. No one has ever suggested that you stop paying a fee for appendectomies. But the point was made that you stop paying for a consultation. Yet this is common practice in a serious cardiac, where a consultation is considerably more time consuming, not only consuming of time, but also of mental efforts in arriving at a proper solution which may or may not be life-saving and for this, then, the Medical-Surgical sets the policy. Fifteen dollars is the fee for this. For an appendectomy the fee is quite different. The inequity is there. People want to raise their voice and say this is inequitable. Dr. Reich has raised his voice; I raised my voice. I understand you have your problem. It probably can't be solved in your program, but the problem does exist, I submit.

Dr. Alfano: I agree with you, Dr. Alexander. But we do not have unlimited funds. We have a specific sum of money. The Plan attempts to distribute that money in the most equitable fashion it can. In many respects we attempt to establish proper relationships between services and fees. From premium income, we know the amount of money we have. By actuarial studies and opinions, we are told how much we can spend. So that there have to be specific amounts established for different procedures. We know that in some instances a gastrectomy or a neurosurgical procedure should be paid more than $350; but we can't do it. Actuarially, we have limits. We have to establish limits somewhere. You might say that our schedule is a pretty good schedule up to the more specialized procedures; then we are way off. Perhaps that's true and that's only because of the fact that our income is limited. We have a certain amount of money which can be distributed and we attempt to distribute it in the most equitable fashion that we can, taking into consideration fair fees for the most common procedures.

Dr. Joshua N. Zimskind (Mercer): Surgical fees, I believe, are now about what they were 30 years ago for the same procedures. This is interesting, but true. The surgeons accept them because they feel that that's about what they should be; yet they are what they were 30 years ago.

Before an officer of a society publishes his personal opinions and gripes in a society's bulletin, it should be approved by the Council of his society. If he wants to write to the newspaper, that's all right. But before he uses the official organ of his county society, his Council should approve.

Dr. Reich: Wouldn't you love your surgical paper amended by a critical group of first-class surgeons before your paper is published? Would you submit the paper you write to a group of surgeons to pass on the competence of the paper before it's even published?

Dr. Zimskind: What I'm talking about is if you are going to attack a part of the Medical Society setup; or if you are going to say that you are in favor of the John Birch Society; or if you are going to say you are opposed to the John Birch Society. Before you publish that in your official county medical society bulletin, it should be passed on by the Council.

Dr. Reich: President Kennedy is doing that now, too, isn't he? He is filtering information now, too, before it's permitted out to be published. Is that what you are referring to? Anyway, I was told by the preceding President, by my Executive Secretary, the page is mine to do as I please. I don't think I've abused the privilege. I have been complimented by other members of my Society.

Dr. Harry Commando: I am a surgeon but am now with Blue Shield. I want to say something about medical fees and this $175 appendectomy we've heard about so much today. It was said that if a man comes in and does a consultation on a coronary, he gets $15. He actually gets $25. The assumption is that every coronary is a fatal disease and everybody is terribly worried about every cor-

onary. And that all appendectomies are minor diseases and never cause any worry. Now, let's follow this coronary through to its logical conclusion.

That $25 is for a consultation fee. That isn't the end of the Plan liability. That case is still under the care of some doctor who is going to be paid something. Even if it is a mild coronary, for three weeks somebody is going to get $130 beyond that $25, so we are up to $155 there. And if it stays there longer than three weeks, that doctor has the privilege of charging his regular fee for the days not covered in the policy.

Now, let's take this appendectomy. A surgeon is called in in consultation. If he sees the patient seven days before the operation, or six days before the operation, *he gets no fee for that consultation* if he does the surgery. That $175 includes the consultation.

If this happens to be a ruptured appendix with peritonitis and distention and ileus, that patient is likely to stay in the hospital for six weeks. His total fee, if he is a participating doctor, is $175. He cannot charge for any additional days.

I just want to keep the record straight. That $25 for that coronary isn't all that the Plan is liable for.

DR. REICH: May I say, Doctor, I am really sorry for you surgeons and that's why I'm not criticizing. I'm talking *for* the medical men, not *against* surgeons. Some of the men have told me there is injustice toward surgeons, too, and I'll take up your cudgel. I think you should be treated better.

I lost an uncle last Sunday, a senior citizen in New York City, over the age of 70. He had the first stage of a prostatectomy, after which he had a cystotomy. But his poor wife had to put up $750 for the surgeon, and then he said it would have to be another $750 for the second stage. My uncle fooled them—he died.

DR. ALFANO: Remember that payment by the Plan for a surgical procedure includes the post-operative care rendered in hospital. The Plan has always had the policy that payment will include only the services rendered during hospitalization. It does not include any visits either prior to hospitalization or following discharge from hospital when the admission is for surgery.

DR. JOHNSON (Mercer): Comparing the local costs of surgery to those in the rest of the country, as gathered by *Medical Economics*, I don't think the surgeons of this area can be accused of over-charging. I have felt for many years that some sort of scheduling for medical diseases could be developed. I wonder if we could have some short discussion as to why fee scheduling medical diseases is not offered. In this way, possibly the internists could get a little better gauge as to whether they are being propery paid or not. This coronary would be so much, pneumonia would be so much, cerebral accident would be so much, and so on.

DR. ALFANO: Our payments are on the basis of services actually rendered. If we were to pay for, let us assume, a coronary on a package basis it's possible that the coronary patient may die after two or three days and yet we would have established a fee that would normally cover six weeks of care. We would then be going way beyond the intent of the contract, that payment by the Plan is for services rendered. If services are not rendered for a full six weeks, under your system then the Plan would have to pay the entire package fee for the care that was rendered on a patient who expired after two days, and that would not be equitable. On the other hand, in the surgical procedure, you can package surgical procedures more so than you can a medical disease.

DR. ANDERSON: Do you reduce the surgical fee if the appendectomy patient dies on the second day?

DR. ALFANO: No. If the appendectomy was done, he will receive that payment.

DR. ANDERSON: But you stated your basis as the pre-operative and post-operative care. There would be no post-operative care there.

DR. REICH: Right, if the patient did not get the post-operative care when he died on the second day. Why should the whole fee then be paid?

DR. ALFANO: The surgical procedure was done. The doctor receives the one fee, as Dr. Commando explaned, for a surgical procedure which includes post-operative care regardless of the length of post-operative care. If the patient is in for six weeks or six days, the fee is the same. So if the patient dies after the surgery, the fee remains the same.

DR. REICH: I'm not quarreling with the surgeons. They earn what they get. But the medical man ought to get what he earns, too. The pool has to be re-arranged. The surgeon will not receive much less than he gets anyway. There is such a thing as justification for a rise in fees, too, from the public. Not enough is being said about value for value received.

DR. DONNELLY: May I say to Dr. Alexander that Dr. Commando's patients don't die on the second day. They are all discharged.

(LAUGHTER)

Dr. Johnson: In surgery we sometimes take out an appendix that is unnecessary, we are paid for that. Medically I think there is a certain error in scheduling surgical procedures at so much per operation. There is an error in fee-scheduling medical entities at so much each. But we are often told in other areas of discussion, that the average of the whole procedure will come up with an acceptable figure. The aggregate fee-pool is simply not big enough. We are distributing a great deal of medical care at a reasonable price. Some work should be done toward scheduling fees for medical entities even though there is an inherent error as there is in the scheduling of surgical fees.

Dr. Commano: Treating medical diseases on a package basis has been attempted by the Plan in consultation with the Society of Internists. We did this before we adopted the concept of "critical care." For two years and several reports there were meetings between our fee committee and the internists' committee. We asked them to give us a list of diseases that could be treated as a package—coronaries, status asthmaticus, and so on. They tried to come up with a list and at the end of two years and three conferences they gave up.

Today we have heard only from surgeons and internists. But I hear it from pediatricians, obstetricians, neurosurgeons, and others. I still say that the money of this Plan is fairly distributed. I say this because everybody is complaining. Nobody is satisfied. The pie is too small to satisfy everybody. We distributed only thirty-seven and a half million dollars this year.

We did get a 15 per cent increase in premiums, because we had been operating in the red for several years. With this came an admonition by the Commissioner of Banking that he will permit only one raise in the schedule for doctors' fees. He said he hoped the obstetricians would use a little restraint and not all of them charge us the maximum. But he absolutely forbid us to change the schedule. He said no part of this raise must be used to increase doctors' fees. This was widely published in the press.

Dr. Alfano: There seem to be no further questions. I think you all for attending this session, and will consider the meeting adjourned. Thank you.

(The meeting was adjourned at 5:40 p.m.)

198th Annual Meeting
May 16-20, 1964, Haddon Hall, Atlantic City

1. *Scientific Exhibits*

Applications for space in the scientific exhibits will be accepted up to, and including, December 16, 1963. Notification of the committee's action will be made soon thereafter.

Members are cordially invited to apply for space in the scientific exhibits at the 1964 annual meeting. Register your name to receive an application form by contacting the Executive Offices of MSNJ, P.O. Box 904, Trenton 5, New Jersey.

2. *Scientific Papers*

The committee on Scientific Program invites members to submit titles and brief abstracts of scientific papers they wish to present at the 1964 annual meeting.

The scientific sessions will be scheduled as follows:

Monday morning, May 18, 1964

Allergy, General Practice (joint session)
Pediatrics, Urology (joint session)
Clinical Pathology, Obstetrics and Gynecology (joint session)

Monday afternoon, May 18, 1964

Orthopedic Surgery
Surgery
Medicine, Metabolism (joint session)

Wednesday morning, May 20, 1964

Dermatology
Gastroenterology and Proctology, Otolaryngology, Radiology (joint session)
Rheumatism

Wednesday afternoon, May 20, 1964

Anesthesiology, Cardiovascular Diseases, Chest Diseases (joint session)
Psychiatry and Neurology
Ophthalmology

Send to the Executive Offices by August 30, 1963, your name, address, title and brief abstract, and indicate the appropriate session for your paper.

Dinner-Dance

Monday Evening, May 13, 1963

The speakers' section of the program was convened at 9:15 p.m., Dr. Jesse McCall, Toastmaster.

THE TOASTMASTER: Mrs. Torppey, Members of the Woman's Auxiliary of The Medical Society of New Jersey, Members, Guests, Friends of the Society, Distinguished Visitors, Dr. Wegryn, Edna Mae, My Dear on My Right, and All of Those Who are Friendly to My Good Friends, Louis Wegryn and Edna Mae:

Welcome to this party. I am glad to see so many bright-eyed and bushy-tailed, but that goes along with bright eyes. We are here to help the Woman's Auxiliary of The Medical Society honor our 170th President. He has done many things during this past year and prior to this past year to deserve the honor. I'm not going to list them now. I'm going to try, if we possibly can, to conduct the program so you will get the most enjoyment.

Officially to welcome you at this time, I'm going to ask the President of the Woman's Auxiliary to take the podium and talk to you for a moment. Mrs. Torppey.

(Applause)

MRS. JOHN J. TORPPEY: Thank you, Dr. McCall.

I am indeed happy and honored to bring greetings of the Woman's Auxiliary to The Medical Society of New Jersey to our fellow members of The Medical Society. My wish is for fun in this exciting room; for relaxation. To the members of the Auxiliary and to our many friends, my wish to all of you is an evening of great relaxation, delicious food, and entertainment. Thank you for giving me the privilege of being with you tonight.

(Applause)

THE TOASTMASTER: Just a short time ago I had the doubtful pleasure of riding on the bumpy Pennsylvania Railroad from Newark to Washington. I sat in the dining car for a short while. About five o'clock in the afternoon, a tipsy gentleman came in and sat opposite me. He announced his plans for the evening: a double Scotch, a rare steak. Then he fixed me right squarely in the eye and he said, "I don't understand you damned Yankees anyway."

I was shocked, my friends. I was born in Tadpole, Virginia, which is almost as big as Newton, New Jersey where I now work. My son is a graduate of the University of Virginia. I had a grandfather who fought with Jackson in the Valley. My daughter went to Macon in Lynchburg—another daughter is going to Hunts College in Roanoke. So I am called a "damned Yankee." This was before the integration headlines hit the papers, too, you know.

I thought that this is rather difficult for me under any circumstances because the Scotch was all right; the rare steak was all right; and I don't understand damned Yankees myself, so that was all right, too.

There is very little humor in this: but there is a moral to this story. He didn't know that I was a Southerner. I think when you are going to stand up and talk, sit down and eat at the same time you should know whom you are standing up with and whom you are sitting down with to eat.

I'm going to introduce the people that you are eating with, from the first table.

(Dr. McCall then introduced the guests)

THE TOASTMASTER: The time has come to honor specifically rather than generally, as I have been trying to do with my random remarks, and others have also been attempting to do, the President of The Medical Society of New Jersey. This is an annual event, as you know; and the presentation of the Fellow's Key to the retiring President becomes one of the center high spots of this particular evening.

The honor of presenting that key has been reserved, by tradition, for the Immediate Past-President, in this particular case, Dr. Ralph Buchanan.

(Applause)

DR. RALPH M. L. BUCHANAN: Thank you, Jesse.

Honored Guests. Lou, I'll get to you in a second. For a guy last year who was just ready to be pushed off to the end of the table, I don't know whether Dr. Torppey or Dr. Booth will be Master of Ceremonies next year or not, but it looks as though you're in the spot kids.

Lou, would you come forward, please? Just about 365 days ago I turned over to you the gavel which is symbolic of the presidency of The Medical Society of New Jersey. For me

to try to go over the highlights of your year's activities and everything that you have done in the betterment for the State of New Jersey is not appropos at this time and I'm sure I couldn't do it adequately.

I don't think at any other time have the Fellows in the audience come up and been here on the presentation of this key. I'm sure that we have Dr. Butler. I think he is our senior Fellow here at the present time. I would like him to come up in the front of this table. I would like Dr. Clyde Bowers to come up here. I would like Dr. Elton Lance to come up here to be so honored in the presentation of this key to our Lou Wegryn.

Dr. Butler, Dr. Elton Lance, and our own Jesse McCall, our Toastmaster. Of course, he is up here without an invitation on my part.

(Applause as the Fellows come forward)

DR. BUCHANAN: Now, tell me, my worthy Fellowettes—Fellows, have you ever seen anything like this before?

DR. BUTLER: Never mind the seniority.

DR. BUCHANAN: Lou, as a symbol of what you have done for New Jersey and particularly The Medical Society of New Jersey, it is my privilege and honor to present to you this key with which we accept you into our Honored Society—the Fellows of this Medical Society.

(Applause)

DR. WEGRYN: Thank you. In accepting this key I assure you that I will not use it to lock my doors and go into hibernation. Instead I'll make every effort to open many a door in behalf of organized medicine and especially the free enterprise system.

Thank you.

(Applause)

THE TOASTMASTER: I had planned at this point to add some special remarks of my own because of my particular respect for this gentleman who has just been honored. I haven't known Lou as long as many of you here; certainly not as long as those who have worked with him in Union County. I began to know him a little more in a personal way several years ago in connection with his then summer home at Lake Hopatcong, which is close to my own bailiwick. That was associated largely with lighter pleasures, like floating around the lake in a motorboat. It was some time after that before I found out he was also interested in ski slopes and some of this vigorous stuff that I can't tolerate too well in New Hampshire. This involved eight or nine-hour drives in the course of a given afternoon or evening in order to get there, get your feet warm and your hands warm and things of that type. He is a vigorous soul, I can assure you.

One of the things that I admired the most is a vigorous mind. This guy has his mental fingers in more pies than almost anyone that I know. And the individual who comes into contact with him, either aggressively as an opponent or amiably, as a cohort, is going to be sadly awakened and sadly disappointed if they misjudge him in the matter of acuity, memory, vigorous thought, and certainly definite opinions. Now, that last particular point I'm going to modify just a bit.

You know, you can admire the left only if you get a little right of the right, only if you get to the left. You admire the center only if you have contact with both ends of the particular horn. That's rather devious. But Lou rarely ever lets anyone know just exactly where he does not stand, rather exactly where he does stand. This is why I have admired him and why I'm going to continue to.

Now, I'm going to ask for a little help here. I may be stumbling. I want the Union County representation, if you will, just for a moment, do you mind standing just to indicate further support for this particular Fellow?

(Applause)

Now, don't get too restless here. There are a couple of other individuals who in the last few hour have spoken to me about wanting to be recognized from the floor.

Dr. William Cox, who represents the staff as President of the Alexian Brothers Hospital.

DR. WILLIAM COX: Dr. McCall, Guests of Honor, Honored Guests, Louie, Edna Mae: In behalf of the medical staff of the Alexian Brothers Hospital, it affords me great pleasure to give you this small gift in love and esteem from us. May God bless you, give you long life and prosperity, prevent you from all harm and evil.

DR. WEGRYN: Thank you very much.

(Applause)

THE TOASTMASTER: Dr. Edward McDonald, President of the staff of St. Elizabeth's Hospital.

DR. MCDONALD: Dr. McCall, Honored Guests, Dr. Wegryn: As a representative of the staff of St. Elizabeth's Hospital, it is my pleasure to present to you this small gift which is a symbol of the esteem in which we hold you, Dr. Wegryn, for the efforts you have made to preserve the free practice of medicine in this State.

DR. WEGRYN: Thank you.

(Applause)

THE TOASTMASTER: If I were in your fix, Lou, I would want to say something, but I don't know what I'd have to say.

DR. WEGRYN: Well, Mr. Toastmaster, maybe I should start this way. Honored Guests and Members, Delegates of The Medical Society of New Jersey, their wives, and the Auxiliary: I wish to thank each and everyone of you for participating in this fine ovation in my behalf.

I have only but a small task before me at the present time in doing honor to our outgoing President of the Woman's Auxiliary—Mrs. Torppey.

During the past year we have crossed many a time and we have been at many meetings together. I must admit that she had a chauffeur, Dr. Torppey, who would be with her on most occasions. And I likewise had a chauffeur trying to catch up on notes—my beloved wife, Edna Mae.

(Applause)

At this time, in recognition of the work done by Mrs. Torppey, it is indeed an honor, as the outgoing President, to present to Mrs. Torppey this Fellowette Key.

And I was told—I must tell you this—I must be mighty careful how I pin this on. Congratulations.

MRS. TORPPEY: Thank you very much.

DR. WEGRYN: Did you notice I took my glasses out? When you get around sixty, you have to look very carefully where you go and what you do.

I'm not up here for a speech, so thank you very much, and remember that I shall stay with you and continue to work, as mentioned before, in behalf of our Society. Thank you.

(Standing ovation)

THE TOASTMASTER: In 1945 I was sitting out the remainder of World War II in Texas, at Camp Fannon. We had a lot of time on our hands—please, Miss Rand, don't take this the wrong way—when a brother officer gave me a copy of "The Fountainhead." At that time I didn't even know how to pronounce the author's first name and I didn't know anything about the situation at all; but I enjoyed the book immensely. I had no notion at that time that I would ever meet the author or authoress, as it turns out to be. But the authoress of that particular book is our guest speaker tonight. I have since found out that the name is not Ann, but Ayn. The last name is Rand; the husband, O'Connor. We got that all straightened out tonight, although I almost made him a female, or was that another one I made a female?

Ayn was born in St. Petersburg, Russia; graduated from the University of Leningrad. She came to the United States in 1926. She is a naturalized American citizen; married to Frank O'Connor, who is an artist. She is a novelist, the author of—I'm sure more than just the two listed here—of "Atlas Shrugged," a more recent book, and "The Fountainhead" which I mentioned. She is co-editor and co-publisher of *The Objectivist Newsletter*, a monthly journal of ideas; which deals with the application of her philosophy—objectivism to the issues and the problems of today's culture. Miss Rand.

(Applause)

MISS AYN RAND: Ladies and Gentlemen, and Dr. Wegryn: Since freedom and individual rights have always been my particular concern, The Medical Society of New Jersey will always have a very special meaning for me as the "State of the Doctors' Revolt." Therefore, I will begin, as I did once before, by expressing my admiration for Dr. Henriksen and the group of doctors who signed his resolution. They took a heroic stand. The storm of vicious denunciations unleashed against them at the time showed that they had delivered a dangerous blow to the welfare-statists. More than any other single factor, it was Dr. Henriksen's group that demonstrated to the public the real nature of the issue, prevented the passage of the King-Anderson Bill. This saved this country from socialized medicine—so far.

Their action was an eloquent example of the fact that only a strong, uncompromising stand—a stand of moral self-confidence, on clearcut, consistent principles—can win.

But there are grave danger signs that the medical profession as a whole—like every other group today—will ignore that example and pursue the usual modern policy of caution and compromise. Such a policy is worse than futile: it assists and promotes the victory of one's own enemies. The battle is not over. The King-Anderson Bill will be brought up again. If the doctors are defeated, they will be defeated by their own hand, or, rather, by their own mind.

I want, therefore, if I may, to make certain suggestions to the medical profession, on the subject of how *not* to fight against socialized medicine.

The majority of people in this country—and in the world—do not want socialism. Yet it is growing. It is growing because its victims concede its basic moral premises. Without challenging these premises, one cannot win.

The base of socialism is the altruist mor-

ality. Altruism claims that man has no right to exist for his own sake; that self-sacrificial service to others is the only moral justification of his existence.

The only political theory consistent with such a moral doctrine is collectivism, which, in all its variants—socialism, fascism, communism or welfare-statism—claims that the individual has no rights and that his life belongs to society.

The strategy of the Kennedy administration, and of all welfare-statists, consists of attempts to make people accept certain intellectual "package deals," without letting them identify and differentiate the various elements, and equivocations, involved. The deadliest of such "package deals" is the attempt to make people accept the collectivist-altruist principle of self-immolation under the guise of mere kindness, generosity or charity. It is done by hammering into people's minds the idea that need supersedes all rights; that the need of some men is a first mortgage on the lives of others; and that everything should be sacrificed to the undefined, undefinable grab-bag known as "the public interest."

Doctors have no chance to win if they concede that idea and help their enemies to propagate it.

Yet, unfortunately, the ideologic policy of most spokesmen for the medical profession—such as the American Medical Association—is as permeated by the collectivist-altruist spirit as the pronouncements of the welfare-statists. The doctors' spokesmen declare, in net effect, that selfless service to their patients is the doctors' only goal; that concern for the needy is their only motive; and that "the public interest" is the only justification of their battle.

The sole difference is this: the voices of the welfare-statists are brazenly, self-righteously overbearing, while the voices of the doctors' spokesmen are guiltily, evasively apologetic.

Whom can one expect the people to believe and to follow?

People can always sense guilt, insincerity, hypocrisy. The lack of a morally righteous tone, the absence of moral certainty, have a disastrous effect on an audience—an effect which is not improved by the triviality of the arguments over political minutiae. And the terrible thing is that the doctors' spokesmen give an impression of guilty evasiveness while the right is on their side. They do it by being afraid to assert their rights.

They are afraid of it because they do not believe that they possess any rights—because they have conceded the enemy's premises—because they have no moral base, no intellectual guide lines, no ideology, no defense.

Consider, for instance, the Canadian doctors' struggle in Saskatchewan. The doctors went on strike against the full-scale socialized medicine instituted by the provincial government. They won the battle; and lost the war. In exchange for a few superficial concessions, they surrendered the principle for which they had been fighting: to permit no socialized medicine in the Western hemisphere.

They surrendered, even though the overwhelming sympathy and support of the Canadian people were on their side (except for the intellectuals and the labor unions). They were defeated, not by the power of the socialists, but by the gaping holes in their own ideologic armor.

They had been fighting, properly, in the name of individual rights, against the enslavement of medicine by totalitarian-statists controls. Then, under the pressure of the usual intellectual lynching, under the hysterical, collectivist charges of "anti-social selfishness and greed," they made a shocking change in their stand. Declaring, in effect, that their rebellion was not directed against socialized medicine, as such, but against the high-handed, arbitrary manner in which the government had put it over, their spokesmen began to argue that the government plan did not represent "the will of the people." The ideologic kiss of death was a statement by Dr. Dalgleish, the strikers' leader, who declared that if a plebiscite were taken and the people voted for it, the doctors would accept socialized medicine.

Could they deserve to win, after that? They could not and did not.

Consider the full meaning of Dr. Dalgleish's statement. It meant the total repudiation of individual rights and the acceptance of unlimited majority rule, of the collectivist doctrine that the people's vote may dispose of an individual in any way it pleases. Instead of a battle for the integrity of a doctor's professional judgment and practice, it became a battle over who should violate his integrity. Instead of a bottle against the enslavement of medicine, it became a battle over who should enslave it. Instead of a battle for freedom, it became a battle over a choice of masters. Instead of a moral crusade, it became a petty quarrel over political technicalities.

This led to the ludicrous spectacle of the alleged individualists arguing for democratic mob-rule, and the socialists righteously upholding the parliamentary form of government.

Those who doubt the power of ideas should note the fact that the doctors' surrender took place five days after Dr. Dalgleish's statement.

The text of the agreement reached between the doctors and the government contained the

following horrifying sentence: "The doctors fear that if the government becomes their only source of income they are in danger of becoming servants of the state and not servants of their patients."

A more abject statement of self-abnegation could not be hoped for or extorted by the most extreme collectivist.

No self-respecting labor union would declare that its members are "servants" of their employers. It took so-called "conservatives" to declare that professional men—and of so responsible, so demanding, so unusually skilled a profession as medicine—are the "servants" of their patients or of anyone who pays them.

There were two collectivist "package deals" working in the Canadian tragedy: the concept of democracy and the concept of service.

The term "democracy" was put over on us many decades ago. In its original political meaning, "democracy" is the theory of unlimited majority rule. It is the doctrine that the majority may do anything it pleases, that it may vote away the rights of a minority and dispose of an individual's life, liberty and property until such time, if ever, as he is able to gather his own majority gang.

The political philosophy of freedom and its product, the political system of the United States, is not based on unlimited majority rule, but on its opposite: on individual rights which are not to be alienated by majority vote or minority plotting. Thus, majority rule operates only in the strictly delimited sphere of political affairs and may not violate individual rights which are outside and above the sphere of political power.

Today, the word "democracy" has become a sloppy rubber term that can be stretched to mean anything. Most people use it to mean some vague form of freedom. But the collectivists are now trying to cash in on its original meaning and many people are confused, wondering whether one is morally obliged to accept anything that the majority may choose to decree. One is not and should not be and should realize that that is a doctrine of pure collectivism.

The "package deal" attached to the concept of "service" consists of a crude equivocation and a cruder evasion. In the language of economics, the word "service" means work offered for trade on a free market, to be paid for by those who choose to buy it. In a free society, men deal with one another by voluntary, uncoerced exchange, by mutual consent to mutual profit, each man pursuing his own rational self-interest, none sacrificing himself or others. In a free market, all values—whether goods or services—are traded, not given away.

This is the opposite of what the word "service" means in the language of altruist ethics. To an altruist, "service" means unrewarded, self-sacrificial, unilateral giving, while receiving nothing in return. It is this sort of selfless "service" to "society" that collectivists demand of all men.

One of the grotesque phenomena of the twentieth century is the fact that the "package deal" of "service" is most vociferously propagated by the "conservatives." Intellectually bankrupt, possessing no political philosophy, no direction, no goal, but clinging desperately to the ethics of altruism, such "conservatives" rest their case on a cheap equivocation: they proclaim that "service" to others (to one's customers or clients or patients or "consumers" in general) is the motive power and the moral justification of a free society. They evade the question of whether such "services" are or are not to be paid for, are or are not to be unilateral and unrewarded.

But if "service to the consumers" is our primary goal, why should these masters pay us or grant us any rights? Why shouldn't they dictate the terms and conditions of our work?

If socialized medicine comes to the United States, it is such "conservatives" that the doctors would have to thank for it, as well as their own spokesmen who recklessly play with an intellectual poison of that kind.

Doctors are not the servants of their patients. No free man is a "servant" of those he deals with. Doctors are traders, like everyone else in a free society. They should bear that title proudly, considering the crucial importance of the services they offer.

The pursuit of his own productive career is, and, morally, should be, the primary goal of a doctor's work, as it is the primary goal of any self-respecting, productive man. But there is no clash of interests among rational men in a free society. There is no clash of interests between doctors and patients. In pursuing his own career, a doctor does have to do his best for the welfare of his patients. This relationship, however, cannot be reversed. One cannot sacrifice the doctor's interests, desires and freedom to whatever the patients (or their politicians) might deem to be their own "welfare."

Many doctors know this, but are afraid to assert their rights. They dare not challenge the morality of altruism: neither in the public's mind nor in their own. Others are collectivists at heart, who believe that socialized medicine is morally right and who feel guilty while opposing it. Still others are so cynically embittered that they believe that the whole country consists of fools or parasites eager to get something for nothing; that morality and

justice are futile, that ideas are impotent; that the cause of freedom is doomed; and that the doctors' only chance lies in borrowing the enemy's arguments and gaining a brief span of borrowed time.

The last is usually regarded as the "practical" attitude for "conservatives."

But nobody is as naive as a cynic, and nothing is as impractical as the attempt to win by conceding the enemy's premises. How many defeats and disasters will collectivism's victims have to witness before they become convinced of it?

Contrary to the modern mentality, the middle of the road is the most impractical of all positions. In any issue, it is the most consistent of the adversaries who wins. One cannot win on the enemy's premises, because the foe is then the more consistent; and all of one's efforts serve only to propagate the enemy's principles.

Most people in this country are not moochers who seek the unearned, not even today. But if all their intellectual leaders and the doctors themselves tell them that doctors are only their "selfless servants," they will feel justified in expecting and demanding unearned services.

When a politician tells them that they are entitled to the unearned, they are wise enough to suspect his motives; but when the proposed victim, the doctor, says it too, they feel that socialization is safe.

If you are afraid of people's irrationality, you will not protect yourself by assuring them that their irrational notions are right.

Collectivism as a cultural, intellectual power died in World War II. What we have today is only its lethargic aftermath: an ideologic vacuum moved by the forces of routine confusion and despair. A small minority, the collectivist intellectuals, are taking advantage of the vacuum by default in the absence of any intellectual opposition.

Ideas can be fought only by means of ideas. People are ready to accept the cause of freedom and to join a crusade for individual rights. The national response to the stand of Dr. Henriksen's group has demonstrated this. But compromise, evasions, and altruistic platitudes will not do it.

As doctors, what would you say if someone told you that you must not try to cure a deadly disease; you must give it some chance; you must reach a compromise with cancer or with coronary thrombosis or with leprosy? You would answer that no compromise is possible because this is a battle of life or death. The same is true of your political battle.

Would you follow the advice of someone who told you that you must fight tuberculosis by confining the treatment to its symptoms, that you must treat the cough, the fever, the loss of weight; but that you must refuse to consider or to touch its cause, the germs in the patient's lungs, in order not to antagonize the germs?

Do not adopt such a course in politics. The principle, and the consequences, are the same. It is a battle of life or death.

The advocates of "Medicare" admit that their purpose is not to help the needy, the sick or the aged. Their purpose is to spare people the so-called embarrassment of a means test; that is, their purpose is to establish the principle and precedent that some people are entitled to the unrewarded services of others, not as charity, but as a right.

Can you placate, conciliate, temporize or compromise with a principle of that kind?

In its issue of March 22, 1963 the magazine *The Washington World* carried a printed debate on the question: should the United States adopt Medicare program tied to social security? The affirmative answer was reviewed by Representative Frank Thompson, a leading advocate of Medicare. I quote from Representative Thompson:

> "We are vitally committed to providing adequate health insurance to the aged as a matter of right and not on the basis of indigence. We believe that as many people as possible should be spared the degrading need for public assistance."

Consider fully what this means. A man receives medical services which are paid for by the public treasury, out of public funds taken by taxation from the public. These are services which doctors are compelled by law to provide, whether they care to or not. What is that if not public assistance of the most immoral kind, since it is not even voluntary charity but forced, compulsory, extorted assistance?

Mr. Thompson seems to regard voluntary public assistance as degarding; but forced public assistance, he implies, is conducive to the dignity of its recipients. Why? Because such recipients are entitled by right to the involuntary servitude of others.

Ladies and gentlemen, you will not win your case until and unless you are ready to declare that you find such proposals degrading, as any man of self-esteem would find slavery degrading. That is the heart of the issue. All the other aspects of your fight are only secondary consequences.

It is not somebody else's need that should be the focus of your campaign, but your own

need, your need of freedom and your right to it.

Let me indicate the kind of moral and intellectual ammunition which you hold and should use if you want to make your case clear to the public. In its issue of May 3, 1963 *Time* Magazine carried a story about the progress of American surgery under the eloquent title of "The Best Hope of All." It was a startling, a truly stunning story on the gigantic achievements of American medicine. As the story indicates, these achievements were created by men who were individualists and egotists in the highest sense of these words; that is, men of unusual ability, of independent judgment, of enormous ambition and courage, the courage to be innovators. Let me quote from that story in *Time*:

"Many surgeons are extremely good and a few are great. What makes the difference? 'To be great,' says the Cleveland Clinic's Dr. Donald Effler, 'a surgeon must have a fierce determination to be the leader in his field. He must have a driving ego, a hunger beyond money. He must have a passion for perfectionism.'"

"The great surgeon's egoism is reflected in a selective amnesia. Practically any one of them, asked to name the three greatest living surgeons, has difficulty in thinking of two others."

"Individualists down to their physical characteristics, great surgeons show that even their skilled hands need be of no particular design."

This might be merely a humorous exaggeration, but remember that great surgeons have earned the moral right to a self-confidence of that kind.

As the article states, "In the operating room all the surgeon's knowledge must be instantly available for decisions upon which life depends."

The article is accompanied by color photographs of seven major operations that would strike any layman, even this somewhat hard-boiled one, with all incredulous speechless admiration.

That, ladies and gentlemen, is your case against socialized medicine—that, not the financial needs nor the stodgy vanity of any patients, young or old, rich or poor.

Could that kind of skill, courage and dedication that created those achievements continue to function under government controls, taking orders from little bureaucrats whose sole distinction is political pull? Can any man of integrity take orders from anyone and act against his own judgment? The more he loves his work, the less flexible and obedient he will be or can be. Tell that to the public. Tell them how much they owe you and what they will lose when and if you lose your freedom.

Government controls—any degree or touch of government controls—are a stifling, deadening influence. It is precisely the innovator, the non-conformist, the man of genius that such controls stop, paralyze and eliminate first and then progressively all other able, competent men with the degree of ability setting the priority of destruction.

Look at the television industry. In spite of all the bureaucrats' protestations about freedom of speech, we know what government controls are doing to television. We can all see what a pall of timed mediocrity is crushing that industry which has to exist under the constant threat of a potential crack-down for unspecified offenses by the arbitrary whims of bureaucrats. If that is what controls do to an industry which deals predominantly with amusement, what will they do to a profession which deals with issues of life or death every moment of the day, with life or death hanging on a doctor's decision? What will bureaucratic threats or orders do to a doctor's mind in that moment of decision? Tell the public to think of that.

In conclusion, I should like to ask you to consider a statement from my novel "Atlas Shrugged," made by a surgeon who went on strike against socialized medicine. "Let them discover the kind of doctors that their system will now produce. Let them discover in their operating rooms and hospital wards that it is not safe to place their lives in the hands of a man whose life they have throttled. It is not safe if he is the sort of man who resents it; and still less safe if he is the sort who doesn't."

I thank you.

(APPLAUSE)

THE TOASTMASTER: Miss Rand, I'm sure that I convey the wish of this group in thanking you for your presentation. Our program tonight does not allow or has not provided for a question and answer interval. It might be that that would be profitable. Certainly my impression would be tonight that it takes an objectivist really to present an objective view of the doctor, which I think Miss Rand has done.

Now we have a change of tempo, ladies and gentlemen. Direct your attention to the front of the room, away from the microphone and from the head table. You will find there, in just a moment, direct from the Statler Hotel in Boston, one of America's outstanding singing teams: Dick Court and Jeannie Saunders.

(The program was concluded at 10:05 p.m.)

Book Reviews • • •

Clinical Obstetrics and Gynecology. The Newborn, edited by Michael Newton, M.D. Office Gynecology, edited by Roger B. Scott, M.D. New York, 1962. Hoeber Medical Division of Harper & Bros. Pp. 320. Illustrated. A Quarterly Publication. (Subscription $18 a year)

The individual volumes of this series are uniformly excellent, and this one is no exception. Any volume containing articles written by a number of contributors must necessarily vary in style, interest to the reader, and to some extent, quality.

This volume is in two parts, designated "The Newborn," and "Office Gynecology." It appeared to this reviewer that the former was much more carefully selected, particularly Batson's article on hyperbilirubinemia, and Segal and Graham's article on the respiratory distress syndrome. Both are penetrating and scholarly discussions of very important subjects.

On the other hand, the section devoted to office gynecology seems somewhat pedagogic, although well worth a quick reading.

On the whole, this volume is a worthy member of this series, and is interesting reading for the obstetrics-gynecology specialist.

PERCY L. SMITH, M.D.

Physical Diagnosis. By Ralph H. Major, M.D. and Mahlon H. Delp, M.D. Philadelphia, 1962. Saunders. 6th ed. Pp. 355. ($7.50)

This finds its greatest use as a textbook for the medical student. It is an excellent refresher for the older practitioner. It is well illustrated, including many illustrations from former editions and new ones appearing for the first time in this issue.

The text includes an excellent chapter on history-taking and recording. This chapter was formerly at the end of the book; a less logical position, since one begins with a history and then proceeds through inspection, palpation, percussion and auscultation.

The rest of the book follows an orderly and logical sequence for diagnosis with chapters on inspection, head and neck, chest, lungs, heart, pulse, blood pressure, abdomen, genitalia, and extremities. There are also chapters giving the physical findings in diseases of the lungs and in cardiovascular diseases.

The final chapter, on the nervous system, is a good review for physicians who do not limit their practices to neurology.

This well-written, easily read book gives excellent coverage to the subject. It is well worth the price.

P. GORDON DAWSON, M.D.

Diagnostic Tests in Infants and Children. Hans Behrendt, M.D. 2nd Edition. Philadelphia, 1962, Lea & Febiger. Pp. 617. 72 Illustrations, 117 Tables. ($15)

The reviewer is amazed at the complex of details that goes into a book describing the diagnostic tests in infants and children. To become familiar with the many advances in this field requires a knowledge of chemistry and biology which the medical schools of my day did not present. There is an orderly progression of subject matter ranging from fat, protein, carbohydrate metabolism, acid base electro-lyte tests and other tests of this nature; to, and including, tests of a more clinical and less laboratory nature, such as hearing and vision tests, motor function tests, and muscle excitability tests.

Particularly functional to pediatricians are the lucid expositions on Rh, Hr tests and endocrine function tests. The newer tests for inborn errors of metabolism are also included. All these are calculated to measure the functioning or malfunctioning of all the organ systems of the body.

This book is strictly a guide and a reference work, set up primarily for pediatricians, but useful to general practitioners, biologists, chemists and laboratory workers. The tables of norms and deviations are particularly useful. There are sections on interpretation of the normal and discussions of the differential diagnostic significance of abnormal findings, as well as functional responses in relation to age and development.

RALPH NEIL SHAPIRO, M.D.

Treatment of Injuries to Athletes. Don H. O'Donoghue, M.D. Philadelphia, 1962, W. B. Saunders Co. Pp. 649. Illustrated. ($18.50)

Dr. O'Donoghue here offers a guide to the overall care of athletic injuires. The common minor injuries (such as contusions, sprains, and strains) are considered in detail for each area of the body. The therapy of each is well outlined. Particularly helpful are the line drawings and excellent descriptions of the methods of bandaging and strapping.

The diagnosis of the more major injuries (such as fractures and dislocations) are outlined in a satisfactory manner. However, except for the knee, no detailed therapy of these injuries is given. Injuries of the face, cranial cerebral injuries, injuries of the chest and abdomen are discussed too briefly. This book is helpful for the care of minor trauma and in the diagnosis and preliminary care of the more serious injuries. It is, however, not a substitute for standard fracture and orthopedic textbooks.

ROBERT GEORGE GREENE, M.D.



BULK IS BASIC

METAMUCIL® IS BASIC...

(brand of psyllium hydrophilic mucilloid)

Metamucil corrects constipation in pregnant patients without disturbing either the rhythmic or digestive functions of the gastrointestinal tract.

By adding a soft, hydrophilic, easily-compressed bulk to the diet, Metamucil augments and reinforces the natural bulk stimulus to intestinal peristalsis and the defecation reflex. This purely local action softens hard fecal masses, increases muscle tone and helps reestablish the normal rhythm of elimination.

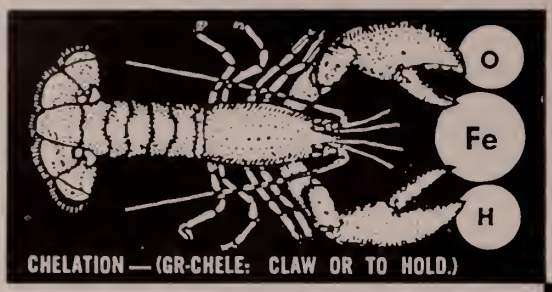
Since its action is not systemic and not habit forming, Metamucil may be safely administered throughout pregnancy.

Average Adult Dose: One rounded teaspoonful of Metamucil powder (or one packet of Instant Mix Metamucil) in a glass of cool liquid.

Metamucil is available as Metamucil powder in 4-, 8- and 16-ounce containers and as flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

G. D. SEARLE & CO., Chicago 80, Illinois

Research in the Service of Medicine



The FIRST Hematinic to Contain BOTH CHELATED IRON and CHELATED MINERALS Assuring a Truly Flavorful, Better Tolerated Iron Therapy.

ADVANTAGES —
Chelated Iron PLUS 4 Chelated Minerals • High Therapeutic Effectiveness • Less Irritation — even on empty stomach • No Tooth Stain • Less Toxic • B-Vitamins for Added Hemopoietic Activity • Pleasant Flavor • Economical

KELATRATE
LIQUID HEMATINIC
CHELATED IRON-MINERALS and VITAMINS

FORMULA —
Each 5 cc. (one teaspoonful) contains:

Iron (as Ferraus Betaine Citrate)	30 mg.
Cobalt (as Cobaltous Betaine Citrate)	0.1 mg.
Manganese (as Manganese Betaine Citrate)	1.0 mg.
Zinc (as Zinc Betaine Citrate)	1.25 mg.
Magnesium (as Magnesium Betaine Citrate)	6.0 mg.
Vitamin B-1	1.5 mg.
Vitamin B-2	1.2 mg.
Vitamin B-12	6.0 mcg.
Niacinamide	10 mg.
Panthenol	10 mg.

In an exceptionally pleasant tasting base.

Comprehensive literature and samples on request.

S. J. TUTAG & CO.
DETROIT 34, MICHIGAN

TUTAG

LAFAYETTE RADIO of Newark

Headquarters for . .

STEREOPHONIC HIGH FIDELITY SYSTEMS and COMPONENTS
for Home and Office

•

Lafayette Radio

24 Central Ave. - Newark 2

Phone: MArket 2-1661

Specially made for
DIABETICS Under Medical Advice
and those on a
restricted sugar diet!

BORDEN'S
SPECIAL FORMULA
Ice Cream

* * *

Artificially sweetened . . . only 125 calories per ¼ pint serving. 4 popular flavors.

* * *

At Most Borden, Reid, and Ricciardi Ice Cream Dealers

Flavoring Improves Palatability of Acidophilus Milk

In the treatment of acne vulgaris and such gastro-intestinal disorders as simple chronic constipation and simple diarrhea, patient resistance to ingestion of Acidophilus may be controlled if flavor is improved by stirring 1 to 2 teaspoons of Jell-O powder into each glass of Acidophilus Milk before serving. Most popular flavors are raspberry, cherry, orange-pineapple, blackberry, and strawberry. For patients on low-calorie diets, substitute D-Zerta for Jell-O. Add a few drops of Sweeta or Sweet-10 to the flavored Acidophilus for a sweeter drink.

WALKER-GORDON ACIDOPHILUS

2% butterfat, made from Walker-Gordon Certified Milk cultured with 300-500 million acidophilus bacilli per ml. Available through leading milk dealers.

WALKER-GORDON CERTIFIED MILK FARM, Plainsboro, N. J.

SWinburne 9-1234 (N. Y. WAlker 5-7300; Phila. PEnnypacker 5-3465)

SYLVAN HOSPITAL and NURSING HOME

Trenton & Grand Avenues **Box 146** **West Trenton, N. J.** **TU 2-0236**

MARTA VOL-TRETTER, M.D.
Medical Director
Member American Psychiatric Assoc.

W. J. HOLLENDONNER, M.D.
R. G. BARRY, M. D.
Fellow American Psychiatric Assoc.

ELEONORE La COUR, R.N.
Superintendent

For the Specialized Care and Treatment of
NERVOUS AND PSYCHOSOMATIC DISORDERS

THERAPIES AS INDICATED FOR THE INDIVIDUAL CASE:

• Insulin Biological • Electroshock • Pharmacotherapy • Psychotherapy

Accredited and Licensed (PMH 5) by N. J. Dept. of I. & A. Cooperating Hospital, Hospital Service Plan of N. J.

MRS. MARY J. BALL

BOARDING HOME FOR THE AGED

141 SO. BURNETT STREET ORange 3-4305 EAST ORANGE, N. J.

BROADLOOM CARPETS — ORIENTAL RUGS

Rugs Washed, Repaired and Stored

B. SHEHADI & SONS, Inc.

CHATHAM
400 Main Street — MErcury 5-8100

EAST ORANGE
51 Central Ave. — ORange 3-5382

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever copillary or venous bleeding presents a problem. KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with core on patients with o predisposition to thrombosis.



KOAGAMIN®

parenteral hemostat

Each cc contains: 5 mg. oxolic acid, 2.5 mg. molonic acid, phenal 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

CHATHAM PHARMACEUTICALS, INC.
Newark 2, New Jersey

Distributed in Canada by Austin Laboratories, Ltd. • Paris, Ontario

NEW YORK FERTILITY INSTITUTE

For the Investigation of Problems of Human Infertility

The Institute provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

Patients are accepted by the Institute only by doctor referral and returned to the referring physician after appropriate studies have been made, together with a complete detailed report of the findings of the Institute and its consultants and recommendations for therapy. Literature on request.

123 East 89th Street, N. Y. 28, N. Y.

Phone: TR 6-9300

DUGAN'S

"Bakers for the Home"

New - LITE DIET BREAD

(White Bread Baked Without Shortening)

Calories per Slice 42 Calories per oz. 70

ALSO

SALT-FREE BREAD
GLUTEN AND PROTEIN BREADS
100% WHOLE WHEAT
100% Whole Wheat Crackers

New York New Jersey
Connecticut Pennsylvania

"At Your Door or To Your Store
It's DUGAN'S for BETTER Baked Goods"

Phone for Delivery

HUmboldt 2-6007 in Newark

(or your local phone book for branch nearest you)

"Prescribe with Confidence"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR
FOR MEN - WOMEN - CHILDREN



SOLD ON Rx ONLY
OUTFLAIR SHOES
FOR CLUB FEET

177A JEFFERSON AVE.
PASSAIC, N. J.

69 WESTWOOD AVE.
WESTWOOD, N. J.

350 MAIN ST.
HACKENSACK, N. J.

Dennis Brown Splints — in all sizes — carried in stock

FAIR OAKS HOSPITAL

SUMMIT, NEW JERSEY

CRestview 7-0143

OSCAR ROZETT, M.D.
Medical Director

MOLLIE KENNEDY, R.N.
Director, Nursing Service

EDWARD R. DUTY, M.D.
Clinical Director

N. M. JANI, M.D.
S. D. ESTRADA, M.D.
Associate Psychiatrists

THOMAS P. PROUT, JR.,
Administrator

AN 85 BED INTENSIVE TREATMENT PSYCHIATRIC UNIT

Certified by
The Joint Commission on Accreditation of Hospitals
The Central Inspection Board, American Psychiatric Assn.









Protects your angina patient better than vasodilators alone

'Miltrate' contains both pentaerythritol tetranitrate, which dilates the patient's coronary arteries, and meprobamate, which relieves his anxiety about his condition. Thus 'Miltrate' protects your angina patient better than vasodilators alone.

Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

Dosage: 1 or 2 tablets *before meals* and at bedtime. Individualization required.
Supplied: Bottles of 50 tablets.

CML-9646

Miltrate®
meprobamate 200 mg.+
pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*

ADAMS & SICKLES
W. STATE and PROSPECT STS.
TRENTON, N. J.
24-HOUR PRESCRIPTION SERVICE
Physicians' Supplies
Hospital Supplies
Trenton—Owen 5-6396

F. G. Hoffritz, Opticians
GUILDCRAFT OPTICIANS
Zenith Hearing Aids
30 PARK PLACE
Phone LO. 8-7628 ENGLEWOOD, N. J.

AMITY NURSING HOME
Ringoes, N. J.
●
Professional Nursing Care to the Aged and Chronically Ill
Mrs. K. Heck
Miss R. Reedy
Flemington 1452-J4

ST. BENEDICT'S PREPARATORY SCHOOL
520 HIGH STREET
Newark 2, New Jersey

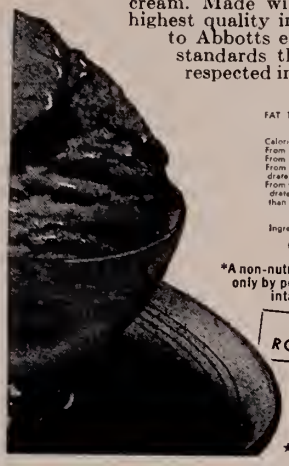
NOW! DIABETICS CAN ENJOY
(UNDER MEDICAL ADVICE)

Abbotts

ARTIFICIALLY SWEETENED

ICE CREAM

Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards — standards that are most highly respected in the dairy industry



COMPOSITION
FAT 10.52% PROTEIN 3.71%
CARBOHYDRATES 20.40%

	Per 100 Gm.	Oz. Avoir.	Oz. Fluid
Calories	191.42	54.27	32.85
From Fat	94.68	26.84	16.25
From Protein	14.84	4.21	2.55
From Carbohydrates as Lactose	20.24	5.74	3.47
From Carbohydrates other than Lactose	61.68	17.48	10.58

Ingredients: Cream, Milk, Sorbitol, Stabilizer and 0.11% Cyclamate Calcium*

*A non-nutritive artificial sweetener for use only by persons who must restrict their intake of ordinary sweets.

IN HANDY ROUND PINTS

At Abbotts and Jane Logan Dealers
Abbotts Dairies

WHO PAYS THE OFFICE RENT?

And telephone bill...and utilities...and employee salaries...*if YOU are sick or injured?*

Physicians Mutual Insurance Company (The Doctors' Company) will help pay all of your usual office expenses when you are sick or disabled—if you are the fortunate owner of our new, low-rate Office Overhead Expense Policy.

Premiums are tax deductible, too!

Write today for free information . . without obligation.

PHYSICIANS MUTUAL INSURANCE COMPANY
115 South 42nd St. Omaha 31, Nebraska

PARKWAY NURSING HOME



1201 PARKWAY AVE.
Trenton, N. J.
Tel. 882-6900

No Steps!
Ranch Type
New audio-visual call system from every patient to Nurses.

One of New Jersey's newest, most modern and completely equipped Nursing and Convalescent Homes, catering to the Convalescent, Aged, and Chronically Ill. Private and Semi-private rooms.

- Referring physician has full medical privileges
- Complete 24-hour general nursing care
- Physical rehabilitation department
- Beauty parlor. Air-conditioned dining room, lounge, and lobby. Spacious patios.
- Ultra modern interiors with artistic color scheme
- Stainless steel kitchen tiled to ceiling
- Special diets. Planned social and recreational activities
- Residential section

REASONABLE RATES — YOUR INSPECTION INVITED

PARKWAY NURSING HOME

NEW JERSEY STATE LICENSED — MEMBER OF AMERICAN NURSING HOME ASSOCIATION

buy direct SAVE 40% on ALBERT ACAN quality controlled X-ray developer and fixer

YOUR COST ONLY **$28.20** (REGULAR PRICE $47.00)

- acan solutions reduce exposure time . . . films are sharply defined; easy to interpret.
- New "Con-Pak" cubitainer; simplifies storage; eliminates breakage; no oxidation.
- Solutions are filtered for purity; dilute readily; last longer.

MONEY BACK GUARANTEE

Use one complete change of Acan solutions (entire contents of one cubitainer each of Developer and Fixer). If you are not completely satisfied, return the remaining cubitainers (3 each of Developer and Fixer) and we will refund your total purchase price.

Albert Acan X-Ray Solutions, Inc.
58-09 28th Avenue, Woodside 77, N. Y. 212 RA 1-4300 201 UN 3-6511

☐ Please ship 1 case of Developer and 1 case of Fixer (sufficient chemicals to make 20 gallons of Developer and 20 gallons of Fixer) at the SPECIAL REDUCED PRICE OF $28.20.

☐ Please ship 1 case of Developer and Fixer (sufficient chemicals to make 10 gallons of Developer and 10 gallons of Fixer) at the MONEY SAVING OFFER OF $15.70.

NAME .....
ADDRESS .....
CITY ..... ZONE ..... STATE .....

Ricci's **Shoes, Inc.**

(Specialists in Prescription Shoe Fittings)

43 KINGS HIGHWAY, EAST
HADDONFIELD, NEW JERSEY

PHONE HA. 9-2243

ROMA SAVINGS AND LOAN ASS'N.

485 HAMILTON AVENUE
Trenton 9, New Jersey

INSURED SAVINGS

Phone: LY 9-9301

The Morristown Rehabilitation Center

66 MORRIS STREET **MORRISTOWN, NEW JERSEY**

JEFFERSON 9-3000



NATHAN KAPLAN, M.D., Physiatrist
MARY E. JOHNSON, Chief Therapist

ANN G. McMANUS, R.N.
Director of Nursing Service

AUDREY E. TAHLMORE
Administrator

A 38-bed rehabilitation unit specializing in orthopedic and neurological disabilities. Speech therapy, Occupational therapy and psychological evaluation available.

- - - - - -

AMERICAN HOSPITAL ASSOCIATION ACCREDITATION
MEMBER NEW JERSEY LICENSED NURSING HOME ASSOCIATION

How Lyons Institute Serves the Medical Profession

For the past eleven years Lyons Institute of Medical, Dental and X-ray Technology has been training high school graduates to serve the medical profession as:

MEDICAL TECHNOLOGIST • MEDICAL TECHNICIAN • MEDICAL ASSISTANT
X-RAY TECHNICIAN • MEDICAL SECRETARY

Many hundreds of our graduates are employed by physicians, hospitals, clinics, laboratories, pharmaceutical concerns and private industry. If you are seeking qualified personnel in any one of the above fields, our free Placement Bureau is at your Service.

LYONS INSTITUTE of MEDICAL, DENTAL & X-RAY TECHNOLOGY

900 BROAD STREET, NEWARK 2, N. J. **Telephone: MItchell 2-3420**

Director, CRAIG R. GARTH, Captain, U.S. Navy (Ret.)
Approved by the New Jersey State Department of Education

RADON • RADIUM

SEEDS • IMPLANTERS • CERVICAL APPLICATORS

THE RADIUM EMANATION CORPORATION

GRAYBAR BUILDING • NEW YORK 17, N. Y.

Wire or Phone MUrray Hill 3-8636 Collect

CLASSIFIED ADVERTISEMENTS

Send replies to box number, c/o THE JOURNAL
P. O. Box 904, Trenton 5, New Jersey

$5 for 25 words or less; additionl words 10c each
Payable in advance of publication

Forms close 15th of the preceding month.

SURGICAL RESEARCH FELLOW—A Surgical Research Fellow is needed to initiate a program in organ transplantation. Excellent facilities are available in modern research laboratory building. Supervision and assistance of group research team, in well integrated program. Candidates must have some previous surgical experience. Knowledge of research techniques with animals valuable but not essential. Wagman Fellowship plus additional stipend available, depending on qualifications. Apply to Samuel J. Ajl, Ph.D., Director of Research, Korman Building, Albert Einstein Medical Center, York & Tabor Roads, Philadelphia 41, Pennsylvania.

RESIDENT PHYSICIANS—Our resident staff is composed of 5 retired physicians. We can accommodate 2 additional resident physicians with New Jersey licenses. Salary open. Pinehaven Nursing Home & Sanitarium, Inc., Joseph O. Smigel, Executive Director, Bayville, New Jersey. DI 9-2050.

INTERNIST WANTED—To begin part-time practice in Camden suburban area. Established medical building without internist at present. Write Box No. 54, c/o THE JOURNAL.

OPPORTUNITY FOR OPHTHALMOLOGIST—South Jersey, 15 miles from Philadelphia. Suburban medical center (four years old) occupied by five other physicians. Part-time required to start. Write Box No. 54, c/o THE JOURNAL.

TWO PHYSICIANS INTERESTED—In broad training in ophthalmology. Must be licensed in Pennsylvania or eligible for same. Salary with training. Can become qualified for Boards. Reply Box No. 67, c/o THE JOURNAL.

PRACTICE FOR SALE—25-year-old practice for internist or general practitioner in Monmouth County, New Jersey. Beautiful 5-year-old brick home and large 5½ room office; including 200 Ma. x-ray, all new equipment, air-conditioned. Sudden death of physician. Gross well over $50,000. Financing arranged or salary basis. H. M. Swartz, M.D., 138 Cherry Tree Farm Road, Middleton, New Jersey. OS 1-3313.

GENERAL PRACTICE—Large, active, all-year-around, seashore resort. No obstetrics. Retiring in the fall. Will introduce. No down payment, liberal terms. Give complete personal details and references in first letter. Reply Box 65, c/o THE JOURNAL.

NEW BRUNSWICK—"Doctor's Row" 15-room combination office and residence for sale. Telephone between 8:00 a.m. - 9:00 a.m. CH 7-6693.

HOME-OFFICE FOR SALE—In Morris County. Nine-room house, with fully-equipped modern office and established general practice. Doctor is in government service. Write Box 69, c/o THE JOURNAL.

HOME-OFFICE-PRACTICE FOR SALE—Short Hills, New Jersey, near new Saint Barnabas. General practitioner and internist leaving large practice for full-time research. Lovely 6-year-old home with 4 bedrooms plus 8-room suite of completely equipped, air-conditioned offices; ample parking. Contact Warren D. Collins, Realtor, 56 Brick Church Plaza, East Orange, New Jersey. OR 6-9340.

REAL ESTATE FOR SALE—Monmouth County, New Jersey. Physician left to speciallze. Six-year-old split level, excellent condition. Residence and office combination: 3-bedroom residence; 4 rooms fully equipped office. Booming area requiring physician. Price below $30,000, negotiable terms. Call area code 201 CO 4-0449 or write Box No. 50, c/o THE JOURNAL.

PROFESSIONAL SUITE—Prime location, modern air-conditioned building on Chatham Road, Short Hills, New Jersey. October occupancy. Call DR 6-5266 or DR 9-3800.

IRVINGTON—600 square foot suite remaining in new professional buildlng, presently occupled by dentist, allergist, optometrist, and speech therapist. 1146 Stuyvestant Avenue. ES 3-1073, MU 6-0787.

FOR SALE—Brand-new office and dwelling combination. Roman brick ranch house 62 feet long, 6 large rooms, finished basement, ultra modern kitchen, faces one street, 40 foot office (500 square feet) faces other street on corner. Excellent location with parking, convenient to all bus facilities, near public and R.C. school. North Arlington, New Jersey. Phone WY 8-7292 or WY 8-0753.

MEDICAL SUITES FOR RENT—Six and five-room suites available in new professional building in best area of fastest growing community in New Jersey. New hospital ¼ mile away—ample parking space. Population over 25,000 year-round and growing rapidly. No ENT—only one pediatrician. Both urgently needed as are other specialties. Ideal location and opportunity. For information write James C. Fullmer, D.D.S., Oak Ridge Medical Center, Toms River, New Jersey, or call DI 1-1120.

POSITION WANTED—Medical assistants and secretaries. Laboratory and x-ray techs. Well-trained and highly-qualified personnel (male and female) available. Phone CH 2-2330, Ext. 17, Place-

ment Department; or write Physician Director, Eastern School for Physicians' Aides, Department 7, 85 Fifth Avenue, New York 3, New York.

TOMS RIVER, NEW JERSEY—Home and office of retiring doctor. Twenty room, 4-bathroom house with 2 car garage on water front, custom built ten years ago with exceptional features. It is tastefully furnished, landscaped, within yards of boating and bathing on private beach. House, practice and furnishings can be bought for $42,000. Write Box No. 68, c/o THE JOURNAL.

YOUNG PROGRESSIVE

DENTIST

wishes to establish comprehensive general practice of quality. Military obligation completed. Please address all replies to

P. O. Box 274

Cascade, Maryland

THUMBSUCKING

since infancy caused this malocclusion.



THUM TRADEMARK

THUM helped break the habit and teeth returned to normal position.

THUM discourages Nail Biting too

70¢ At Your Drug Store



Sky Lake Lodge and 50 individual cozy cottages high on a beautiful mountain lake. (Alt. 1600 ft.) Naturally wooded setting. Activities for all ages; swimming, sailing, water skiing, fishing, entertainment.

Home cooked food of superlative quality.

Write for color booklet or phone Hawley 226—4596

LEN-A-PE VILLAGE

Tafton, Pike Co., Pa. *in the Poconos*

THE

ORANGE

PUBLISHING CO.

PRINTERS

•

116-118 LINCOLN AVENUE

Orange New Jersey

Office Suites Available - New Medical Building

Kinnelon, New Jersey

Area in need of general practitioner, surgeon, obstetrician, pediatrician, dentist.

HENRY D. RICKER, Broker BUTLER, NEW JERSEY — TE 8-0400

Don't tie your capital to buy. RENT and take a full deduction.

The choice of any medical equipment is yours. RENT from US.

MEDICAL X-RAY RENTALS, INC.

791 LAMBERTS MILL ROAD WESTFIELD, NEW JERSEY

Helps the epileptic to realize his potential

DILANTIN®

(DIPHENYLHYDANTOIN SODIUM)

PARKE-DAVIS



tion to the patient that the seizure phenomena can be adequately controlled with anticonvulsant medication."[1]

At present, diphenylhydantoin sodium is generally regarded as the standard in anticonvulsant medication because of its effectiveness in controlling grand mal and psychomotor seizures.[2-10] It possesses a wide margin of safety, and incidence of side effects is minimal.[4] With this agent, oversedation is not a problem.[3] Moreover, its use is often accompanied by improvement in the patient's memory, intellectual performance, and emotional stability.[11]

Indications: Grand mal epilepsy and certain other convulsive states.

Precautions: Toxic effects are infrequent: allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Eruptions then usually subside. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Megaloblastic anemia has been reported. Nystagmus may develop. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. Periodic examination of the blood is advisable.

DILANTIN Sodium (diphenylhydantoin sodium) is available in several forms including Kapseals,® 0.03 Gm. and 0.1 Gm., bottles of 100 and 1,000.

REFERENCES: (1) Hammill, J. F.: J. Chron. Dis. **8**:448, 1958. (2) Roseman, E.: Neurology **11**:912, 1961. (3) Bray, P. F.: Pediatrics **23**:151, 1959. (4) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (5) Crawley, J. W.: M. Clin. North America **42**:317, 1958. (6) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (7) Ibid.: Postgrad. Med. **20**:584, 1956. (8) Merritt, H. H.: Brit. M. J. **1**:666, 1958. (9) Carter, C. H.: Arch. Neurol & Psychiat. **79**:136, 1958. (10) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (11) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.

14863

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan





Formerly nervous and tense, now better able to...

enjoy hi children

This, in essence, is what happens when place a patient on Librium (chlordiazep ide HCl). Since this agent generally reli anxiety and tension without dulling me clarity or inducing drowsiness, most pati become better able to function norma take an active interest in family and roundings, meet and solve daily proble This antianxiety agent is virtually free f extrapyramidal side effects, and does produce or deepen depression.

Dosage: *Oral*—Usual adult dose in mild to moderate ety and tension is 5 or 10 mg, 3 or 4 times daily; in se anxiety and tension, 20 or 25 mg, 3 or 4 times *Parenteral*—To control acute conditions, the usual adult dose is 50 to 100 mg I.M. or I.V.; not more 300 mg should be given during a 6-hour period. □ **effects:** *Oral*—Drowsiness and ataxia, usually dose-rel have been reported in some patients—particularly elderly and debilitated. Paradoxical reactions, *i.e.*, ex ment, stimulation, elevation of affect and acute rage, been reported in psychiatric patients; these reactions be secondary to relief of anxiety and should be wat for in the early stages of therapy. Other side effects, ally dose-related, have included isolated instance minor skin rashes, minor menstrual irregularities, nau constipation, increased and decreased libido. *Paren* —Following parenteral administration some patients become drowsy or unsteady. The injectable form occasionally produced mild, transitory fluctuation blood pressure. □ **Precautions:** *Oral*—In elderly, de tated patients, limit dosage to smallest effective am to preclude development of ataxia or oversedation more than 10 mg per day initially, to be increased gr ally as needed and tolerated). Until the correct ma nance dosage is established, patients receiving this a should be advised against possibly hazardous proced requiring complete mental alertness or physical co nation. Caution patients about possible combined ef with alcohol. Caution should be exercised in admini ing Librium (chlordiazepoxide HCl) to addiction-p individuals. Careful consideration should be given t pharmacology of any agents to be employed conc tantly—particularly the MAO inhibitors and pheno zines. Observe usual precautions in impaired rena hepatic function. Periodic blood counts and liver f tion tests may be advisable in protracted treatm *Parenteral*—Indicated primarily in acute states. Pati receiving this form of therapy should be kept under servation, preferably in bed, for up to three hours. Ar latory patients should not be permitted to opera vehicle following injection. Reduce dosage when trea patients with impaired renal or hepatic function. injectable form should not be given to patients in sh or comatose states. Reduced dosage (usually 25 to 50 should be used for elderly or debilitated patients, for children.

anxiety and tension relieved
alertness maintained

Librium®
(chlordiazepoxide HCl)

the successor
to the tranquilizers

ROCHE

ROCHE

THE Journal OF

THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since 1904
Copyright 1963 by The Medical Society of New Jersey

Entered as second-class matter Sept. 5, 1906, at the post office, Orange, N. J., under Act of March 3, 1879
Second Class Postage Paid at Orange, N. J.

THE NEW YORK ACADEMY OF MEDICINE AUG 21 1963 LIBRARY

VOL. 60, NO. 8 AUGUST, 1963 50 Cents - $5.00 PER YEAR

CONTENTS—Pages 373 to 412

EDITORIALS— Page

The Research Piper and the Research Tune ... 373
Physicians' Role in Auto Accident Prevention 374
Doctors' Handwriting ... 374

ORIGINAL ARTICLES—

Pleural Effusions—Charles R. Ream, M.D., Elizabeth ... 375

Endotracheal Anesthesia: The Choice for Adenotonsillectomy—Joseph F. Lutz, M.D., Livingston ... 382

Vasa Previa—Donald R. Reisfield, M.D., New Brunswick ... 385

Prevention of Fetal Loss in Diabetes—Joseph A. Fleming, M.D., Montclair ... 389

Hyperthyroidism Treated with Radioactive Iodine—Jonathan C. Gibbs, Jr., M.D.; R. V. Grieco, M.D.; and James E. McKeown, B.A., Jersey City ... 392

ORIGINAL ARTICLES— Page

Hydrochlorothiazide for Postpartum Breast Engorgement—Louis Barth, M.D., Newark 395

Professional Service Corporation Act—Edward Pesin, Newark ... 397

STATE ACTIVITIES—

Child Protective Services in New Jersey ... 391

Trustees Meetings:
May 10, 1963 ... 400
May 15, 1963 ... 400

MSP Statement on Supreme Court Decision 403

Medical Assistance for the Aged in New Jersey ... 404

ANNOUNCEMENTS ... 406

OBITUARIES ... 409

BOOK REVIEWS ... 411

Roster of Officers, Councils, and Committees, 3A-4A

The Medical Society of New Jersey Endorsed Plans of

ACCIDENT AND HEALTH INSURANCE
MAJOR MEDICAL EXPENSE INSURANCE
TERM LIFE INSURANCE

****SIX POINT, HIGH LIMIT ACCIDENT INSURANCE**
(Accidental Death, Dismemberment and other Accident Benefits)

Income Protection (Accident and Sickness Insurance)

$1,200 a month new maximum Basic total disability benefit

ACCIDENT: from 1st day, up to 5 years (Partial Accident Disability, half benefit up to six months)
SICKNESS: from 8th day, up to 2 years

$600 a month new maximum Extended total disability benefit, continuing benefits beyond basic coverage.

ACCIDENT: extended to LIFE
SICKNESS: extended through SEVENTH year

Major Medical

$10,000 maximum for Covered Expenses for each accident or sickness, covering member, spouse, and eligible children. $500 deductible, 20% co-insurance.

Life

$10,000 to **$50,000** of Convertible Term Life Insurance.
(Guaranteed exchangeable at any time into Permanent Cash Value life insurance)

Applications for initial $10,000 policy and additional $10,000 policies up to $50,000 total under this plan considered during the month of November each year*.

** **SIX POINT, HIGH LIMIT ACCIDENT INSURANCE**

Up to $200,000 Six Point, High Limit Accident Insurance, covering accidental death, dismemberment, loss of sight, total and permanent disability, exposure and disappearance for member.

Up to $100,000 for spouse (without disability benefit).

Applications are subject to age limits and other company rules and regulations for acceptance of risks. New members have special privileges during the first few months of membership; ask for specific details if you were recently elected and have not received notification from us.

Information and claim service are as close as your telephone.

E. & W. BLANKSTEEN

E. & W. Blanksteen Agency, Inc.

75 MONTGOMERY STREET JERSEY CITY 2, NEW JERSEY

DElaware 3-4340

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATON, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.
EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154
(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

OFFICERS

President, Jerome G. Kaufman, M.D. ..... Maplewood
President-Elect, Charles H. Calvin, M.D. ..... Perth Amboy
First Vice-President, John J. Bedrick, M.D. .....Bayonne
Second Vice-President, Joseph R. Jehl, M.D. ..... Clifton
Secretary, Marcus H. Greifinger, M.D. .....Newark
Treasurer, Daniel F. Featherston, M.D. ..... Asbury Park

Richard I. Nevin, *Executive Director* ..... Trenton
Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton

TRUSTEES

Samuel J. Lloyd, M.D., *Chairman* (1966) ..... Trenton
Nicholas A. Bertha, M.D., *Secretary* (1965) ..... Wharton
Jerome G. Kaufman, M.D. ..... Maplewood
Charles H. Calvin, M.D. ..... Perth Amboy
John J. Bedrick, M.D. ..... Bayonne
Joseph R. Jehl, M.D. ..... Clifton
Marcus H. Greifinger, M.D. ..... Newark
Daniel F. Featherston, M.D. ..... Asbury Park
Louis S. Wegryn, M.D. ..... Elizabeth
Louis F. Albright, M.D. (1964) ..... Spring Lake
Louis K. Collins, M.D. (1964) ..... Glassboro
Thomas C. DeCecio, M.D. (1965) ..... Cliffside Park
Joseph P. Donnelly, M.D. (1966) ..... Jersey City
Lloyd A. Hamilton, M.D. (1965) ..... Lambertville
Frank J. Hughes, M.D. (1966) ..... Gloucester
John F. Kustrup, M.D. (1966) ..... Trenton
Emanuel M. Satulsky, M.D. (1964) ..... Elizabeth
Carl N. Ware, M.D. (1965) ..... Ocean City

COUNCILORS

First District (Essex, Morris, Union, and Warren Counties) ..... Thomas S. P. Fitch, M.D., Plainfield (1966)
Second District (Bergen, Hudson, Passaic, and Sussex Counties) ..... John L. Olpp, M.D., Englewood (1965)
Third District (Hunterdon, Mercer, Middlesex, and Somerset Counties) ..... Albert F. Moriconi, M.D., Trenton (1964)
Fourth District (Burlington, Camden, Monmouth, and Ocean Counties) ..... E. Vernon Davis, M.D., Moorestown (1966)
Fifth District (Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties) .... Isaac N. Patterson, M.D., Westville (1965)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell, M.D. (1964) ..... Asbury Park
William F. Costello, M.D. (1963) ..... Dover
Joseph P. Donnelly, M.D. (1964) ..... Jersey City
Marcus H. Greifinger, M.D. (1964) ..... Newark
Luke A. Mulligan, M.D. (1964) ..... Leonia
Isaac N. Patterson, M.D. (1963) ..... Westville

Alternates

F. Clyde Bowers, M.D. (1964) ..... Mendham
Frank J. Hughes, M.D. (1964) ..... Gloucester
Joseph R. Jehl, M.D. (1964) ..... Clifton
John F. Kustrup, M.D. (1964) ..... Trenton
Elton W. Lance, M.D. (1963) ..... Rahway
John L. Olpp, M.D. (1963) ..... Englewood

DELEGATES TO OTHER STATES

New York—William F. Costello, M.D. (1963) ..... Dover
Connecticut—Lloyd A. Hamilton, M.D. (1963) .. Lambertville
New York—G. Ruffin Stamps, M.D. (1963) .... Atlantic City
Connecticut—S. Eugene Dalton, M.D. (1963) ..... Ventnor

ADMINISTRATIVE COUNCILS

Legislation

Jesse McCall, M.D., *Chairman* (1966) ..... Newton
Robert E. Murto, M.D. (1964) ..... Trenton
A. Guy Campo, M.D., *Vice-Chm.* (1964) ..... Westville
Nathan J. Plavin, M.D. (1964) ..... North Bergen
Leonard Rosenfeld, M.D. (1964) ..... Ringoes
C. Byron Blaisdell, M.D. (1965) ..... Asbury Park
Charles L. Cunniff, M.D. (1965) ..... Jersey City
William E. Bray, M.D. (1965) ..... Pemberton
Ludwig L. Simon, M.D. (1965) ..... Newark
Henry J. Mineur, M.D. (1966) ..... Cranford
John S. Madara, M.D. (1966) ..... Salem
Winton H. Johnson, M.D. (1966) ..... Hackensack
Samuel J. Lloyd, M.D., *Chairman, Board of Trustees* .. .. *Ex-Officio* ..... Trenton

Medical Services

Irving Klompus, M.D., *Chairman* (1965) ..... Bound Brook
Joseph M. Gannon, M.D. (1964) ..... Plainfield
Andrew C. Ruoff, III, M.D. (1964) ..... Pompton Plains
Donald B. Hull, M.D. (1964) ..... Ridgewood
Durant K. Charleroy, M.D. (1964) ..... Trenton
Nicholas E. Marchione, *Vice-Chm.* (1965) ..... Vineland
Francis J. Benz, M.D. (1965) ..... Chatham
Frederick W. Durham, M.D. (1965) ..... Haddonfield
Frank M. Galioto, M.D. (1966) ..... Bloomfield
Harry R. Brindle, M.D. (1966) ..... Asbury Park
Charles B. Norton, Jr., M.D. (1966) ..... Woodstown
I. Edward Ornaf, M.D. (1966) ..... Camden
Charles H. Calvin, M.D., *President-Elect, Ex-Officio* ..... Perth Amboy

Public Health

John B. Fuhrmann, M.D., *Chairman* (1965)....Flemington
Edwin H. Albano, M.D. (1964) ..... East Orange
Richard E. Berlin, M.D. (1964) ..... Teaneck
Francis R. Meyers, M.D. (1964) ..... Paterson
Elmer J. Elias, M.D. (1964) ..... Morristown
Robert S. Garber, M.D. (1965) ..... Belle Mead
Anthony P. DeSpirito, M.D. (1965) ..... Asbury Park
Estelle T. Milliser, M.D. (1965) ..... Westfield
Peter J. Guthorn, M.D. (1966) ..... Asbury Park
Thomas F. Flynn, Jr., M.D. (1966)..... Woodbury
Carl J. Records, M.D. (1966) ..... Cape May
John P. Coughlin, M.D., *Vice-Chm.* (1966).....Jersey City
John J. Bedrick, M.D., *First Vice-President, Ex-Officio* ..... Bayonne
Roscoe P. Kandle, M.D., Commission of Health, *Consultant* ..... Trenton

Public Relations

John F. Kustrup, M.D., *Chairman* (1965) ..... Trenton
F. Clyde Bowers, M.D. (1964) ..... Mendham
Harry F. Suter, M.D., *Vice-Chm.* (1964) ..... Penns Grove
George E. Barbour, M.D. (1964) ..... Somerville
Norman K. Boudwin, M.D. (1964) ..... Beverly
William P. Mulford, M.D. (1965) ..... Beverly
S. William Kalb, M.D. (1965) ..... Newark
Howard C. Pieper, M.D. (1965) ..... Keyport
Earl L. Warren, M.D. (1966) ..... Paterson
Carroll M. Leevy, M.D. (1966) ..... Jersey City
Francis I. Tomlins, M.D. (1966).....Ridgewood
Josiah C. McCracken, Jr., M.D. (1966) ..... Ventnor
Joseph R. Jehl, M.D., *Second Vice-President, Ex-Officio* ..... Cilfton

SPECIAL COMMITTEES TO THE ADMINISTRATIVE COUNCIL ON MEDICAL SERVICES

Occupational Health

Delma W. Caldwell, M.D., *Chairman* (1964) ..... Linden
Francis M. DeGrace, M.D. (1964) ..... Passaic
Lloyd A. Hamilton, M.D. (1964) ..... Lambertville
Edmund M. Hartmann, M.D. (1964) ..... Bound Brook
Willis B. Mitchell, M.D. (1964) ..... Toms River
Mathilda R. Vaschak, M.D. (1964) ..... New Brunswick
William D. VanRiper, M.D. (1964) ..... New Brunswick

Workmen's Compensation

Joseph A. Lepree, M.D., *Chairman* (1964).....Elizabeth
William J. D'Elia, M.D. (1964) ..... Spring Lake
George A. Glass, M.D. (1964) ..... Somerville
Sanford Lewis, M.D. (1964) ..... Newark
Carl A. Maxwell, M.D. (1964) ..... Morristown
William E. Mountford, M.D. (1964) ..... Trenton
William P. Mulford, M.D. (1964) ..... Beverly
Andrew C. Ruoff, III, M.D. (1964) ..... Pompton Plains
Ralph A. Young, M.D. (1964) ..... Linden
Joshua N. Zimskind, M.D. (1964) ..... Trenton
Edward F. Balsbaugh, M.D. (1964) ..... Parlin

SPECIAL COMMITTEES TO THE ADMINISTRATIVE COUNCIL ON PUBLIC HEALTH

Cancer Control

John L. Olpp, M.D., *Chairman* (1964) ..... Englewood
Conrad M. Bahnson, M.D. (1964) ..... Jersey City
Albert S. Basri, M.D. (1964) ..... Colonia
William E. Bray, M.D. (1964) ..... Pemberton
Frank F. Drews, Jr., M.D. (1964) ..... Englewood
George L. Erdman, M.D. (1964) ..... Summit
Roy T. Forsberg, M.D. (1964) ..... Elizabeth
Sylvan E. Moolton, M.D. (1964) ..... New Brunswick

Child Health

Robert E. Jennings, M.D., *Chairman* (1964)...South Orange
Neil Castaldo, M.D. (1964) ..... Cranford
William J. Farley, M.D. (1964) ..... Nutley
David R. Lyons, M.D. (1964) ..... East Orange
Bernard N. Millner, M.D. (1964) ..... Trenton
Edward J. Thalheimer, M.D. (1964) ..... Vineland
Sydney Tucker, M.D. (1964) ..... Perth Amboy
Geoffrey W. Esty, M.D., *Consultant,* Division of Health Safety & Physical Education, N. J. State Dept. of Health (1964) ..... Trenton

The Chronically Ill and the Aging

Matthew E. Boylan, M.D., *Chairman* (1964) ....Jersey City
Melvin J. Andrews, M.D. (1964) ..... Pennsauken
David Eckstein, M.D. (1964) ..... Trenton
William H. Hahn, M.D. (1964) ..... Newark
William D. Kimler, M.D. (1964) ..... Haddon Heights
Thomas E. Mattingly, Jr., M.D. (1964) ..... Mount Holly
Johannes F. Pessel, M.D. (1964) ..... Trenton
Abram L. Van Horn, M.D. (1964) ..... Far Hills
James B. Butler, M.D., *Consultant* ..... Trenton

Conservation of Hearing and Speech

James H. Spillane, M.D., *Chairman* (1964)....Phillipsburg
Edgar P. Cardwell, M.D. (1964) ..... Newark
Warren E. Crane, M.D. (1964) ..... Trenton
Thomas F. Flynn, Jr., M.D. (1964) ..... Woodbury
Casimir F. Gadomski, M.D. (1964) ..... Elizabeth
Robert F. Roh, M.D. (1964) ..... East Orange
Aris M. Sophocles, M.D. (1964) ..... Trenton

Conservation of Vision

Ralph E. Siegel, M.D., *Chairman* (1964).....Perth Amboy
Henry Abrams, M.D. (1964) ..... Princeton
Alfonse A. Cinotti, M.D. (1964) ..... Jersey City
Samuel M. Diskan, M.D. (1964) ..... Atlantic City
Oram R. Kline, Jr., M.D. (1964) ..... Camden
Harry P. Landis, Jr., M.D. (1964) ..... Palmyra
Robert E. Murto, M.D. (1964) ..... Trenton
D. Blair Sulouff, M.D. (1964) ..... Morristown
Frank B. Vanderbeek, M.D. (1964) ..... Paterson
John T. Worcester, M.D. (1964) ..... Englewood
Domenic Angiuoli, M.D. (1964) ..... Orange

Maternal and Infant Welfare

John D. Preece, M.D., *Chairman* (1964) ..... Trenton
Mary Bacon, M.D. (1964) ..... Bridgeton
Robert A. Cosgrove, M.D. (1964) ..... Jersey City
Allan B. Crunden, Jr., M.D. (1964) ..... Montclair
Henry D'Agostin, M.D. (1964) ..... Wyckoff
Edward Foord, M.D. (1964) ..... Burlington
Theodore K. Graham, M.D. (1964) ..... Paterson
Henry L. Hermann, M.D. (1964) ..... Phillipsburg
Theodore Loizeaux, M.D. (1964) ..... Plainfield
Frank L. Paret, M.D. (1964) ..... New Brunswick
Francis U. Seiler, M.D. (1964) ..... Lawrenceville
Ralph H. Van Meter, M.D. (1964) ..... Moorestown
Renne Zindwer, M.D., N.J. State Dept. of Health, *Consultant* ..... Trenton

Mental Health

Robert S. Garber, M.D., Chairman (1964) .... Belle Mead
Harry Diener, M.D. (1964) ..... East Orange
William Furst, M.D. (1964) ..... East Orange
James B. Goyne, M.D. (1964) ..... Trenton
Evelyn P. Ivey, M.D. (1964) ..... Morristown
Nicholas E. Marchione, M.D. (1964) ..... Vineland
J. Lloyd Morrow, M.D. (1964) ..... Passaic
George A. Rogers, M.D. (1964) ..... Camden
Edward A. Schauer, M.D. (1964)..... Farmingdale
Martin H. Weinberg, M.D. (1964) ..... Hammonton

Rehabilitation

Elmer J. Elias, M.D., *Chairman* (1964) ..... Morristown
E. Vernon Davis, M.D. (1964) ..... Moorestown
Robert F. Dow, M.D. (1964) ..... No. Caldwell
William Kuhn, M.D. (1964) ..... New Brunswick
Thomas F. McLaughlin, M.D. (1964) ..... Metuchen
Robert J. Neville, M.D. (1964) ..... Hackensack
James B. Butler, M.D., *Consultant* ..... Trenton

SPECIAL COMMITTEES

Disaster Medical Services

Jack R. Karel, M.D., *Chairman* (1964) ..... Hillside
R. Winfield Betts, M.D. (1964) ..... Medford
Sidney Ketyer, M.D. (1964) ..... Elizabeth
Morton W. Leach, M.D. (1964) ..... Ventnor
Thomas F. Nevins, Jr., M.D. (1964) ..... Linden
Frank L. Paret, M.D. (1964) ..... New Brunswick
Frank R. Schell, M.D. (1964) ..... Paterson
Roscoe P. Kandle, M.D., *Consultant* ..... Trenton

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., *Chairman* (1964) ....Vineland
John J. Bedrick, M.D. (1964) ..... Bayonne
Albert F. Moriconi, M.D. ..... Trenton
Ralphael E. Remondelli, M.D. (1964) ..... Belleville
Mr. William Allen Steadman, *Consultant* ..... East Orange

Traffic Safety

William L. Sprout, M.D., *Chairman* (1964) ..... Salem
Donald T. Akey, M.D. (1964) ..... Metuchen
R. Winfield Betts, M.D. (1964) ..... Medford
Robert S. Garber, M.D. (1964) ..... Belle Mead
A. M. K. Maldeis, M.D. (1964) ..... Collingswood
Ralph E. Siegel, M.D. (1964) ..... Perth Amboy
James H. Spillane, M.D. (1964) ..... Phillipsburg



NTz Nasal Spray gives prompt, dependable decongestion of the nasal membranes for fast symptomatic relief of hay fever. The first spray shrinks the turbinates, restores nasal ventilation and stops mouth breathing. The second spray, a few minutes later, improves sinus ventilation and drainage. Excessive rhinorrhea is reduced.

NTz Nasal Spray also provides decongestive relief for head colds, perennial rhinitis and sinusitis. Supplied in leakproof, pocket-size, squeeze bottles of 20 ml. and in bottles of 30 ml. with dropper.

NTz® Nasal Spray

NTz is more than a simple vasoconstrictor. It contains [N]eo-Synephrine® HCl 0.5%—the efficacy of which is unexcelled—to shrink nasal membranes and provide inner space; [T]henfadil® HCl 0.1% for topical antiallergic action; and [Z]ephiran® Cl 1:5000 (antibacterial wetting agent) to promote the spread of the decongestant components to less accessible nasal areas.

NTz is well tolerated and does not harm respiratory tissues.

NTz, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium as chloride, refined), trademarks reg. U.S. Pat. Off. 1795M

Winthrop **Winthrop Laboratories**
New York 18, N.Y.



in arthritis: vitamins are therapy

In dealing with the chronic stress of arthritis the physician often faces the problem of nutritional imbalance. High potency B and C supplementation is needed for rapid replenishment of tissue stores of these water-soluble vitamins. STRESSCAPS meet this need and help support the natural metabolic defenses in the disease.

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains: Vitamin B_1 (Thiamine Mononitrate)...10 mg. / Vitamin B_2 (Riboflavin)...10 mg. / Niacinamide...100 mg. / Vitamin C (Ascorbic Acid)...300 mg. / Vitamin B_6 (Pyridoxine HCl)...2 mg. / Vitamin B_{12} Crystalline...4 mcgm. / Calcium Pantothenate...20 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

6310

STRESSCAPS®

Stress Formula Vitamins Lederle

there is nothing "new" about Thorazine®



brand of

chlorpromazine

In the nine years since it became available to American physicians, Thorazine (chlorpromazine, SK&F) has been more widely used, more thoroughly investigated and more extensively documented than any other agent of its type.

Its actions, effects—and side effects—are well known throughout the medical profession. Its efficacy has been clearly demonstrated. And when properly used, its advantages far outweigh any possible disadvantages.

This is why there is nothing "new" about Thorazine (chlorpromazine, SK&F). This is why it remains the first choice in many conditions—and the standard against which other agents are inevitably compared.

This is why it is one of the fundamental drugs in medicine.

SMITH KLINE & FRENCH
LABORATORIES, PHILADELPHIA

SK&F

to bring her back into balance

after menstrual irregularity



an orally active progestogen-estrogen combination

Duosterone®

Ethisterone . . . 10.00 mg. Ethinyl estradiol . . . 0.01 mg. per tablet

Supplementing and supporting ovarian function, DUOSTERONE can help release your patients from the anxiety, discomfort and inconvenience of functional amenorrhea, dysmenorrhea, and dysfunctional uterine bleeding.

Periodic progestational treatment with DUOSTERONE aims at restoring the normal hormonal pattern of the secretory phase of the menstrual cycle, providing an orally active progestogen with an estrogen to prime the endometrium for adequate progestational response.

Dosage: Functional amenorrhea, 5 tablets daily for 5 days. Dysmenorrhea, 1 to 2 tablets daily during the second half of the menstrual cycle, except for the final two days. Dysfunctional uterine bleeding, 5 to 7 tablets daily for 5 days; in mild cases, reduce dose 1 tablet each day.

Side Effects: Ethinyl estradiol may occasionally cause headache, diarrhea, engorgement and tenderness of the breasts, nausea, vomiting, cramping, or skin rash. These side effects usually fade as the patient adjusts to the estrogen.

Cautions and Contraindications: DUOSTERONE is contraindicated in carcinoma of the breast and reproductive organs and should be used with caution in cases of known liver impairment.

Supplied: Bottles of 25 and 100 tablets.

ROUSSEL

Roussel Corporation
155 East 44th Street, New York 17, N.Y.



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain... not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

®WALLACE LABORATORIES / *Cranbury, N.J.*

C30-9133





For dramatic restoration

WINSTROL®

brand of STANOZOLOL

Oral anabolic therapy with this new physiotonic helps restore the patient's: positive protein metabolism; confidence, alertness and sense of well-being.

WINSTROL (stanozolol/Winthrop), a heterocyclic steroid, combines highest potency* with outstanding tolerance, stimulates appetite and promotes weight gain . . . restores a positive metabolic balance. It counteracts the catabolic effects of concomitant corticosteroid or ACTH therapy. WINSTROL (stanozolol/Winthrop) rebuilds body tissue while it builds strength, confidence and a sense of well-being in conditions associated with excess protein breakdown, insufficient protein intake and inadequate nitrogen and mineral retention.

Side Effects and Precautions: Prolonged administration can produce mild hirsutism, acne or voice change. In an occasional patient, edema has been observed and in young women the menstrual periods have been milder and shorter. These side effects are reversible, and patients receiving prolonged treatment should be examined and questioned periodically so that, should side effects appear, the dosage may be reduced or administration of the drug discontinued for a time.

In patients with impaired cardiac and renal function, there is the possibility of sodium and water retention. Liver function tests may reveal an increase in bromsulphalein retention, particularly in elderly patients. In such cases, therapy should be discontinued. Although it has been used in patients with cancer of the prostate, its mild androgenic activity is considered by some investigators to be a contraindication.

Dosage: Usual adult dose, 1 tablet t.i.d. before or with meals; young women, 1 tablet b.i.d.; children (school age): up to 1 tablet t.i.d.; children (preschool age): ½ tablet b.i.d. Available as scored tablets of 2 mg. in bottles of 100. For best results, administer with a high protein diet.

*ANIMAL DATA

Rx WINSTROL
(stanozolol/Winthrop) whenever anabolic therapy is indicated

Winthrop

Winthrop Laboratories, New York 18, New York

AIDS TO:

Diagnosis
Examination
Treatment

New (11th) Edition!
Beeson & McDermott—Cecil-Loeb
TEXTBOOK OF MEDICINE

A new and distinguished team of Editors guides this well-known textbook in its *New (11th) Edition*. It provides precise and thorough descriptions of all those disease entities you are likely to encounter—over 800 in all. Each is discussed fully and completely: *etiology, epidemiology; morbid anatomy; pathologic physiology; symptoms; diagnosis; prognosis; therapy.* Contents range from a commentary on *Patient-Physician Communication* to *Management of Bronchopulmonary Insufficiency.* In this revision you'll find increased emphasis on pathologic physiology; a new section on *Genetic Diseases;* expansion of the material on *Viral Diseases;* reorganization and augmentation of sections on *Bronchopulmonary Disease* and *Gastroenterology;* a brilliant discussion of *Nucleic Acids, Genes, Viruses, and Immunity;* 67 new contributors. *The text is available either as a single volume or a two-volume set.*

Edited by PAUL B. BEESON, M.D., Ensign Professor of Medicine, Yale University School of Medicine; and WALSH MCDERMOTT, M.D., Livingston Farrand, Professor of Public Health, Cornell University Medical College. With contributions by 173 authorities. With the assistance of 5 Associate Editors: ALEXANDER G. BEARN, PHILIP K. BONDY, CARL V. MOORE, MARVIN H. SLEISENGER, the late HAROLD G. WOLFF. 1895 pages, 7⅜" x 10¾", with 238 illustrations. Single volume, $19.50. Two-volume set, $23.50. *New (11th) Edition—Just Published!*

New (2nd) Edition!
Mayo Clinic—CLINICAL EXAMINATIONS IN NEUROLOGY

Here are the proved, successful techniques used at the Mayo Clinic in the neurologic examination. The book is written in concise, practical form—a series of working blueprints. The authors carefully guide the reader in developing his mastery of the clinically useful techniques in this important area of practice. You'll find effective techniques for taking the neurologic history, and reproductions of the various forms the Mayo Clinic staff developed for recording the history and the results of the clinical examination. They give you their order of procedure, their techniques of examination of the cranial nerves, motor function, reflexes, mental function, autonomic function, specific methods of examination for use in the sensory examination, etc. For this up-dated *New (2nd) Edition* the information in all chapters was brought up-to-the-minute. The problems of performing neurological examinations on infants are delineated in a full chapter, and a new chapter is devoted to roentgenographic techniques. You'll find a full measure of practical help in this up-to-date volume.

By Members of the Sections of Neurology and Section of Physiology, Mayo Clinic and Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota, Rochester, Minnesota. 396 pages, 6⅛" x 9¼", illustrated. About $9.00. *New (2nd) Edition—Just Ready!*

Three new EDITIONS from SAUNDERS

New (2nd) Edition!
Graham—THE CYTOLOGIC DIAGNOSIS OF CANCER

This valuable manual (formerly under auspices of the Vincent Memorial Laboratory) discusses the fundamentals, potentials and limitations of cytologic diagnosis of cancer—plus detailed, authoritative guidance on preparation and interpretation of cytologic smears. Material is based on study of *tens of thousands of cases.* Vaginal smears, smears of sputum or bronchial aspirations, urine sediment, gastric secretion and the sediment of serous fluid are all covered. Each chapter begins with an illustration and discussion of a histologic section of a particular tissue. This is followed by: (a) lower-power photomicrograph of a field of classical desquamated cells derived from that epithelium; (b) a higher-power photomicrograph of the same; (c) a colored drawing. In this *New (2nd) Edition* the cytological picture of dysplasia of the uterine cervix, the cytology of esophageal cancer, the cytology of needle aspirations of solid masses, and the cellular aberrations present in pernicious anemia are discussed in separate chapters. The material on histiocytes in vaginal secretion, and the chapter on adenocarcinoma of the uterine corpus are rewritten. Other valuable new chapters cover: the confirmation of unexpected positive reports; the reporting of smears; the identification of cells.

By RUTH M. GRAHAM, Sc.D. (Hon.), Roswell Park Memorial Institute, Buffalo. 387 pages, 6⅜" x 9¾", with 992 illustrations on 311 figures. 32 color plates. About $13.50. *New (2nd) Edition—Just Ready!*

To Order Mail Coupon Below!

W. B. SAUNDERS COMPANY

West Washington Square Philadelphia 5

Please send and bill me:

☐ Beeson & McDermott—Cecil-Loeb *Medicine* . . . 2 vol. set.....$23.50

☐ Single Volume form.....$19.50

☐ Graham—*Cytologic Diagnosis of Cancer*.....About $13.50

☐ Mayo Clinic—*Clinical Examinations in Neurology*.....About $9.00

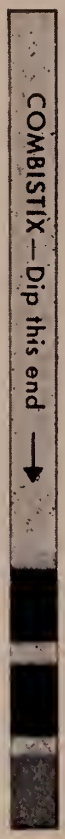
Name.....

Address.....

SJG 8-63

one answer... three minutes





three answers ...ten seconds

DIP AND READ

combistix®

urine protein • glucose • pH

BASIC COMBINATION TEST FOR BEDSIDE AND OFFICE

. . . faster than taking temperature. Detects glucosuria (as in diabetes), proteinuria (as in renal disorder), abnormal pH (as in calcinosis or GU infection). For routine screening of all patients. COMBISTIX—*basic as the stethoscope.*

AMES products are available through your regular supplier. 38263

AMES COMPANY INC Elkhart • Indiana Toronto • Canada



Relieves Anxiety and Anxious Depression

The outstanding effectiveness and record of safety with which 'Miltown' (meprobamate) relieves anxiety and anxious depression has been clinically authenticated time and again during the past eight years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more than any other tranquilizer in the world.

Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

Usual dosage: 1 or 2 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50.

the original meprobamate

Miltown®

WALLACE LABORATORIES / *Cranbury, N.J.*

CM-9240

PROFESSIONAL LIABILITY INSURANCE PROGRAM

officially endorsed by

THE MEDICAL SOCIETY OF NEW JERSEY

PROTECTION for Professional Acts and Professional Premises Liability for members of The Medical Society of New Jersey by the First American Liability Insurance Company.

LOSS CONTROL. Your County Medical Review and Advisory Committee will evaluate malpractice cases and recommend the action which would be most favorable for the Medical Profession, the Defendant Doctor, the Patient and the Public. This program permits understanding of the complex problems involved in such cases and calls for close cooperation between the Medical Profession and Insurance Company.

MEDICO-LEGAL FORMS are furnished to each insured doctor to help in reducing claims or dissatisfied patients. Failure to use forms does not affect the doctor's insurance coverage or his eligibility for insurance.

INSURANCE COUNSELING. Insurance counseling and advice, available at all times, without cost, to help you with your Professional Liability insurance problems.

CANCELLATION. No policy will be cancelled or non-renewed without prior consultation between your Society and the Company and this is a matter of complete cooperation for the best interests of all concerned.

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY

Policies Guaranteed Non-assessable

Professional Liability Department

123 CLEVELAND STREET — ORANGE, NEW JERSEY

Joseph A. Britton, Manager — ORange 3-2575

Home Office: Wakefield, Mass.

Question:

"What is a tranquilaxant?"

Answer:

"A drug that is both a tranquilizer and a muscle relaxant."

TRANCOPAL®
brand of
chlormezanone
is a tranquilaxant

As a tranquilizer, TRANCOPAL (chlormezanone/Winthrop) "is effective in the symptomatic treatment of anxiety."[1] Its tranquilizing properties are similar to those of other mild tranquilizers.[1] Furthermore, it relieves tension in both mind and muscle without interfering with normal activity or alertness.

The muscle relaxant properties[2] of this drug provide an extra dimension of effectiveness...relaxing the spasm which so frequently accompanies psychogenic disorders. Once, the total therapeutic effect of TRANCOPAL (chlormezanone/Winthrop)—a true "tranquilaxant"—is to produce a relaxed mind in a relaxed body.

Unsurpassed Tolerance: Less than 3 per cent of patients develop side effects with TRANCOPAL (chlormezanone/Winthrop), such as occasional drowsiness, dizziness, flushing, nausea, depression, weakness and drug rash. If severe, medication should be discontinued. In most patients, however, side effects are minor and do not necessitate interruption of treatment. There are no known contraindications.

Available: 200 mg. Caplets® (green colored, scored), 100 mg. Caplets (peach colored, scored), each in bottles of 100.

Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; in some patients 100 mg. three or four times daily suffices. Children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Winthrop
WINTHROP LABORATORIES
New York 18, N.Y.

References: 1. A.M.A. Council on Drugs: J.A.M.A. 183:469 (Feb. 9) 1963. 2. Gruenberg, F.: Curr. Ther. Res. 2:1 (Jan.) 1960.

1783M

Abscess
Acne
Amebiasis, acute, intestinal
Anthrax
Bacillary dysentery
Bacteremia
Bartonellosis
Bronchitis, acute
Bronchopulmonary infection
Brucellosis, acute
(IN COMBINATION WITH OTHER ANTIMICROBIAL AGENTS)
Chancroid
Diphtheria
(IN CONJUNCTION WITH ANTITOXIN AND ROUTINE ESTABLISHED THERAPY)
Endocarditis, subacute, bacterial
Genitourinary infection
Gonorrhea
Granuloma inguinale (DONOVANOSIS)
Infections associated with pancreatic fibrosis
Listeriosis
Lymphogranuloma venereum
Meningitis, purulent
Mixed bacterial infection
Osteomyelitis
Otitis
(EXTERNA OR MEDIA)
Pertussis
Pharyngitis
Pneumonia
(WITH OR WITHOUT BACTEREMIA)
Psittacosis
Pyelonephritis, acute and chronic
Rocky Mountain spotted fever
Scarlet fever

proven effective in over

50

disease entities...

Septicemias
(STAPHYLOCOCCAL AND PNEUMOCOCCAL)
Sinusitis
Soft tissue infections
Tonsillitis
Tularemia
Typhus fever
Urethritis
(NONGONOCOCCAL)
associated with tetracycline-sensitive microorganisms, the more important of which are:
STREPTOCOCCI
STAPHYLOCOCCI
PNEUMOCOCCI
GONOCOCCI
SHIGELLAE
RICKETTSIAE
KLEBSIELLAE
and, in particular, with certain species of tetracycline-sensitive microorganisms such as the following:
HEMOPHILUS INFLUENZAE
STREPTOCOCCUS PYOGENES
DIPLOCOCCUS PNEUMONIAE
CORYNEBACTERIUM DIPHTHERIAE
ESCHERICHIA COLI
Surgical and dental preoperative and postoperative prophylaxis
Syphilis
(WHERE THE PATIENT IS PENICILLIN-SENSITIVE)
Typhoid fever
(WHEN CHLORAMPHENICOL IS CONTRAINDICATED)
Agammaglobulinemia or hypogammaglobulinemia and recurring infections
(WITH GAMMA GLOBULIN THERAPY)

ACHROMYCIN® V

TETRACYCLINE HCl WITH CITRIC ACID

SIDE EFFECTS (infrequent and usually mild): glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. CONTRAINDICATIONS: None, but the following precautions should be observed: high-calcium-content foods or drugs should not be taken for at least one-half hour after each dose; avoid excessive accumulation of antibiotics by reducing dosage in patients with impaired renal function; consider possibility of discoloration of teeth during tooth development (late pregnancy, infancy or early childhood).
CAPSULES—250 mg. and 100 mg.; SYRUP; PEDIATRIC DROPS.

Lederle LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York
6421 3

For your elderly arthritic patients



AN EFFECTIVE GERIATRIC ANTIARTHRITIC WITH DISTINCTIVE SAFETY FACTORS

safely indicated – even when **OSTEOPOROSIS** is present

PABALATE-SF, which has been found "superior to aspirin in the treatment of chronic rheumatic disorders,"[1] possesses distinctive **Safety Factors** for elderly arthritics, even when osteoporosis is present: (1) its potassium salts cannot contribute to sodium retention; (2) its enteric coating assures gastric tolerance; and (3) it does not produce the serious reactions often noted during therapy with steroids or pyrazolone derivatives.

In each persian-rose enteric-coated tablet: potassium salicylate, 0.3 Gm.; potassium para-aminobenzoate, 0.3 Gm.; ascorbic acid, 50 mg.

1. Ford, R. A., and Blanchard, K. P.: J.-Lancet 78:185, 1958.

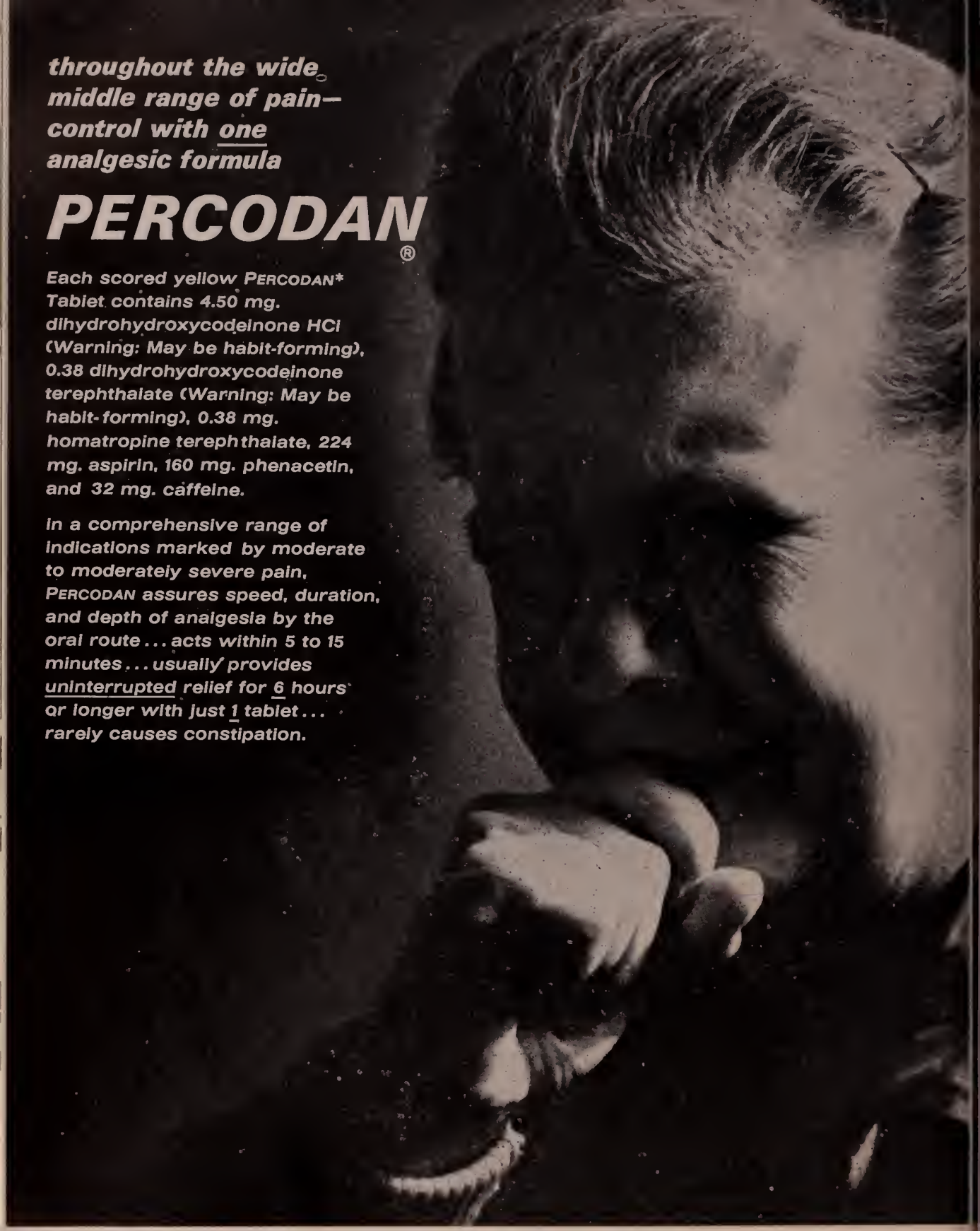
Precaution: Occasionally, mild salicylism may occur, but this responds readily to dosage adjustment. In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Supply: Bottles of 100 and 500 enteric-coated tablets.

Pabalate®-SF

Robins

(the new, convenient way to prescribe Pabalate-Sodium Free)

A. H. ROBINS COMPANY, INC., RICHMOND, VIRGINIA



throughout the wide middle range of pain—control with one analgesic formula

PERCODAN®

Each scored yellow PERCODAN* *Tablet contains 4.50 mg. dihydrohydroxycodeinone HCl (Warning: May be habit-forming), 0.38 dihydrohydroxycodeinone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.*

In a comprehensive range of indications marked by moderate to moderately severe pain, PERCODAN *assures speed, duration, and depth of analgesia by the oral route . . . acts within 5 to 15 minutes . . . usually provides uninterrupted relief for 6 hours or longer with just 1 tablet . . . rarely causes constipation.*

Average Adult Dose—1 tablet every 6 hours. **Side Effects and Contraindications**—Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. **Also available:** PERCODAN®-DEMI, containing the complete PERCODAN formula but with only half the amount of salts of dihydrohydroxycodeinone and homatropine. Both products are on oral Rx in all states where laws permit. Narcotic order required. **Literature on request.**

ENDO LABORATORIES Richmond Hill 18, New York

Endo®

*U. S. Pats. 2,628,185 and 2,907,768

ADVANCE ANNOUNCEMENT . . .

Postgraduate Courses
1963 - 1964

EDUCATION

OFFICE SURGERY
September 25 to November 20, 1963
ARTHRITIS, RHEUMATOLOGY, and ALLIED DISEASES
October 2 to December 18, 1963
DERMATOLOGY
October 3 to December 12, 1963
BASIC ELECTROCARDIOGRAPHY
October 9, 1963 to January 29, 1964
DENTISTRY
1 Day — October 23, 1963
MAMMOGRAPHY
2 Days — October 25, 26, 1963
DISEASES OF THE VASCULAR SYSTEM
February 5 to March 25, 1964
HEMATOLOGY
February 5 to April 8, 1964
ADVANCED ELECTROCARDIOGRAPHY
February 12 to April 15, 1964

ENROLL NOW!

For Information and Application, Write to—
ALBERT EINSTEIN MEDICAL CENTER
Dept. of Postgraduate Medical Education
Philadelphia 41, Pa.

DUGAN'S

"Bakers for the Home"

New - LITE DIET BREAD

(White Bread Baked Without Shortening)
Calories per Slice 42 Calories per oz. 70

ALSO

SALT-FREE BREAD
GLUTEN AND PROTEIN BREADS
100% WHOLE WHEAT
100% Whole Wheat Crackers

New York
Connecticut
New Jersey
Pennsylvania

"At Your Door or To Your Store
It's DUGAN'S for BETTER Baked Goods"

Phone for Delivery

HUmboldt 2-6007 in Newark

(or your local phone book for branch nearest you)



Protects your angina patient better than vasodilators alone

'Miltrate' contains both pentaerythritol tetranitrate, which dilates the patient's coronary arteries, and meprobamate, which relieves his anxiety about his condition. Thus 'Miltrate' protects your angina patient better than vasodilators alone.

Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

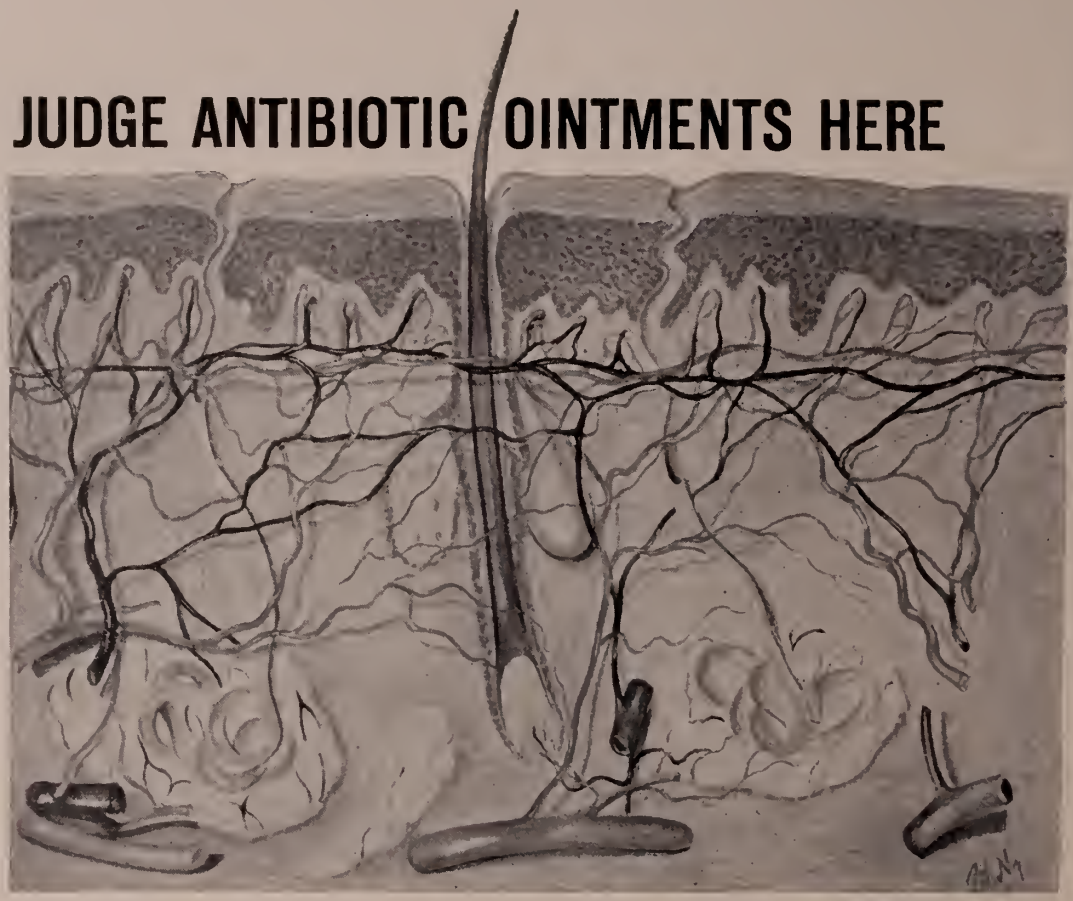
Dosage: 1 or 2 tablets *before meals* and at bedtime. Individualization required.
Supplied: Bottles of 50 tablets.

CML-9646

Miltrate®
meprobamate 200 mg.+
pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Antibiotic Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and rarely sensitizes.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®
brand

POLYMYXIN B-BACITRACIN-NEOMYCIN ANTIBIOTIC OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



Deltasmyl®

Theophylline (120 mg.)
Ephedrine HCl (15 mg.)
Phenobarbital (8 mg.)
(Barbituric acid derivative)
Prednisone (1.5 mg.)

for safer steroid protection from asthma

DELTASMYL® opens the airways and suppresses inflammation by combining the anti-allergic, anti-inflammatory action of prednisone with the bronchodilating, decongestant and quieting effects of theophylline, ephedrine and phenobarbital.

DELTASMYL provides prompt, prolonged relief of asthma with prednisone protection against allergens and stress, and a wider margin of safety through reduction of the effective corticoid dose.

The aim of therapy in asthma should be relief of bronchospasm by means of decongestant and bronchodilating agents—plus prednisone, not just prednisone alone.[1] Uhde[2]—using theophylline-ephedrine-phenobarbital with prednisone—reports an increase of about 25% in the action of prednisone with quicker arrest of inflammation, hypersecretion, and alveolar stasis; a marked sedative action on heart and circulation; improved ventilation. Bopp[3] also has obtained satisfactory results with the same combination, probably through synergistic enhancement of prednisone potency.

Dosage: One DELTASMYL tablet provides symptomatic relief for 4 hours or longer. Not more than 6 tablets should be taken in 24 hours. Withdraw gradually.

Precautions: DELTASMYL contains ephedrine and should not be given with epinephrine since both drugs may cause tachycardia. Carefully observe patients hypersensitive to sympathomimetic amines. Phenobarbital is a barbituric acid derivative which may be habit forming. Despite the low prednisone dose, all precautions and contraindications of corticosteroids must be heeded, since warning signs such as fluid retention or moon face may not be present. When corticosteroids are given to patients with acute or chronic bacterial infections, appropriate protection should be provided.

Contraindications: Hyperthyroidism, cardiovascular diseases, peptic ulcer, diabetes mellitus, psychotic tendencies, ocular herpes simplex, glaucoma, prostatic hypertrophy, Cushing's syndrome, arrested tuberculosis.

Supplied: Bottles of 50 tablets, on prescription only.

References: 1. Barach, A. L. and Bickerman, H. A.: Pulmonary Emphysema, Baltimore, Williams & Wilkins, 1956, p. 523. 2. Uhde, H.: Med. Monatsschr. No. 8, 505, 1959. 3. Bopp, K. Ph.: Medizinische Klinik 53:186, 1958 and Algerie Medicale 62:1081, 1958.

ROUSSEL

Roussel Corporation

155 East 44th Street, New York 17, N.Y.

We still see eye to eye

The recent decision of the New Jersey Supreme Court which held unconstitutional the required approval of Medical-Surgical Plan Trustees by the Medical Society of New Jersey will in no way alter the Plan's close relationship with the Society and its component county organizations. The cooperation of physicians, who provide medical and surgical care to Plan subscribers, makes possible our contribution to meeting the health care requirements of New Jersey Citizens.

No matter what the legal requirements may be, it is our aim, through the continued support and cooperation of The Medical Society of New Jersey, to maintain the 51% participation of doctors, which, incidentally, is required for membership in the National Association of Blue Shield Plans.

The Plan and the Medical Society have seen eye to eye, over the years, on the qualifications necessary in a Plan Trustee. The removal of legal requirements for Society approval of Plan Trustees will not in any way change our established policy of seeking men of calibre similar to that of the able, dedicated and public-spirited Trustees who have contributed so much to maintaining the Plan's high standards of service in the past.

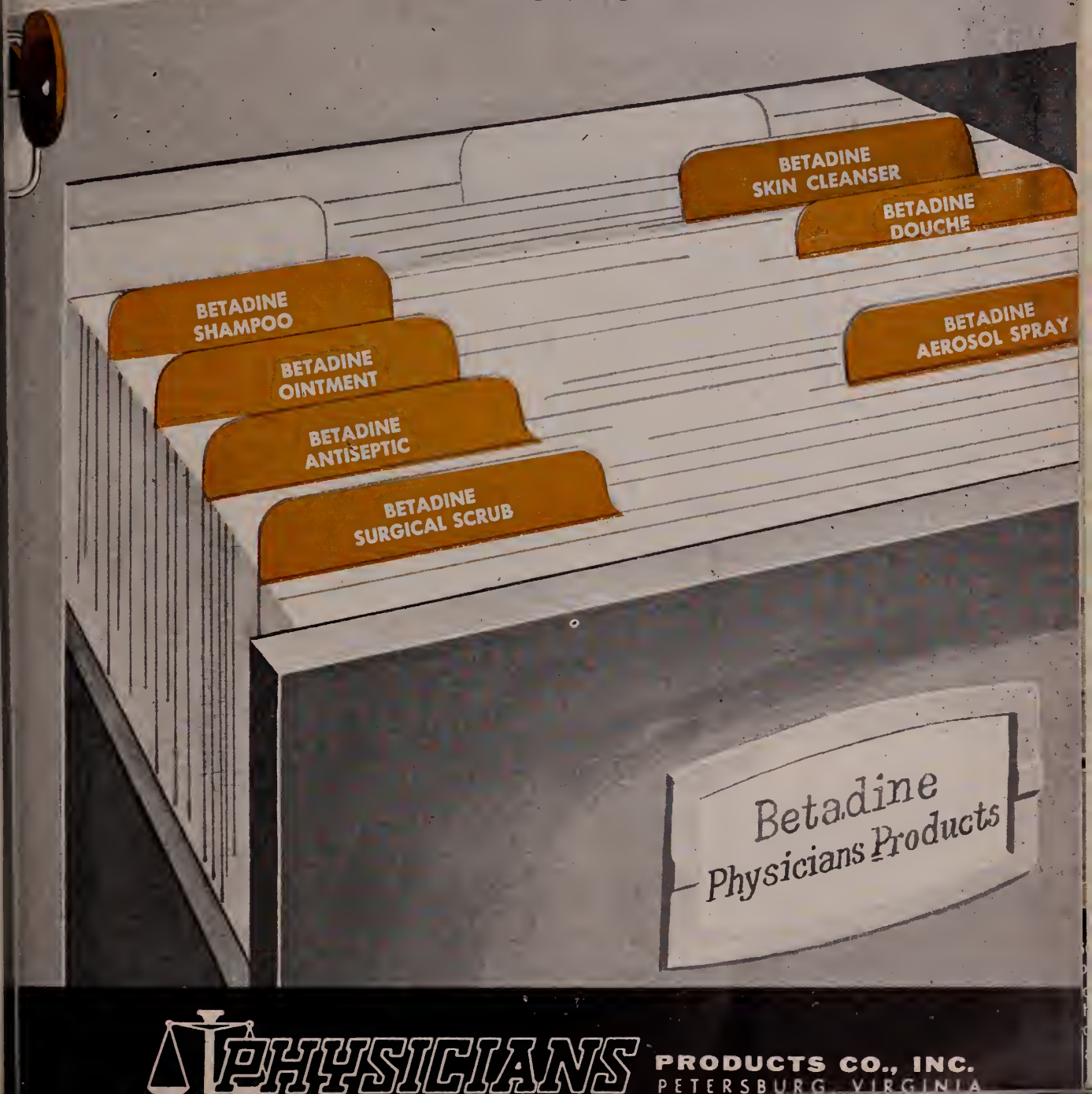
BLUE SHIELD®
MEDICAL-SURGICAL PLAN OF NEW JERSEY
500 Broad Street, Newark

etadine®
vidone-Iodine
roducts
lock a wide
nge of usefulness

Betadine Products, in all seven dosage forn contain povidone-iodine, a complex of polyvin pyrrolidone and iodine, providing all the gerr cidal properties of elemental iodine . . . yet Be dine (povidone-iodine) is nonirritating, nonsen tizing, and nontoxic to skin or mucosa.

Betadine Products are effective in preventing a treating a variety of infections frequently e countered in the practice of otolaryngology, orth pedics and orthopedic surgery, obstetrics a gynecology, oral surgery, pediatrics, surgery a dermatology.

The clinical results reported under various co ditions of use make Betadine (povidone-iodin preparations valuable adjuncts both in the ho pital and in private practice. Literature availab upon request.



PHYSICIANS PRODUCTS CO., INC.
PETERSBURG, VIRGINIA

most effective in the obese diabetic...

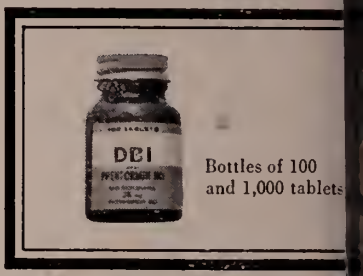
Recent reports suggest... insulin and sulfonylureas may accelerate lipogenesis, fat accumulation, weight gain; thus appear to aggravate obesity in diabetics[1-5]...serum "insulin" levels are often elevated in obese diabetics[2,3,6]...DBI (phenformin HCl) reduces high blood sugars, lowers elevated "insulin" levels, tends to reduce body weight toward normal.[1,3,7-9]

DBI and DBI-TD (phenformin HCl), administered to ketoacidosis-resistant diabetics requiring hypoglycemic therapy: **A.** act to reduce high blood sugar without increasing fat synthesis or weight gain as insulin and sulfonylureas tend to do. **B.** do not increase already elevated endogenous insulin levels; may, indeed, act to restore more normal insulin levels. **C.** favor reduction of weight towards normal.

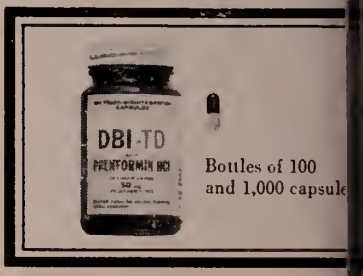
Insulin is still the essential hypoglycemic agent for the ketoacidosis-prone diabetic. However, in the ketoacidosis-resistant obese diabetic phenformin appears to be the hypoglycemic of choice to help avoid weight gain or reduce adiposity, a factor tending to make control more difficult and to increase the likelihood of complications.



Summary: Indicated in stable adult diabetes, sulfonylurea failures and unstable diabetes. Gastrointestinal side effects occurring more o higher dosage levels abate p upon dosage reduction or t withdrawal. Occasionally an dependent patient will show



Bottles of 100 and 1,000 tablets



Bottles of 100 and 1,000 capsule

tion" ketosis (acetonuria w hyperglycemia) which must b ferentiated from "insulin-lack tosis, and treated accordingly with caution in severe liver d Not recommended without inst acute complications (acidosis, infections, gangrene, surgery product brochure for full inform

Bibliography: 1. Williams, R. H.: Text Endocrinology, Ed. 3, Saunders, Phila 1962, p. 610. 2. Gordon, E. S.: Me 11:819, 1962. 3. Grodsky, G. M. et al.: lism 12:278, 1963. 4. Sadow, H. S.: Me 12:333, 1963. 5. West, K. M. and Top Metabolism 10:689, 1961. 6. Yalow, R. Berson, S. A.: Diabetes 9:254, 1960. 7. W et al.: Scientific Exhibit, A.M.A., June Weller, C. et al.: Metabolism 11:1134, Radding, R. S. et al.: Metabolism 11:40

tablets 25 mg. timed-disintegration capsules 5

DBI®

DBI-TD

BRAND OF PHENFORMIN H

U. S. VITAMIN & PHARMACEUTICAL CORP. 800 SEC NEW YOR

LIFTS DEPRESSION ...AS IT CALMS ANXIETY



"I feel like my old self again!" Balanced 'Deprol' therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

Brightens mood...relaxes tension

Energizers may stimulate the depressed patient, but they often aggravate anxiety and insomnia. Tranquilizers may help the anxious patient, but they often deepen depression. 'Deprol' avoids these "seesaw" effects; it relieves both anxiety and depression. Moreover, it does not cause liver damage, psychotic reactions or changes in sexual function.

Slight drowsiness and, rarely, allergic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

Usual Dosage: 1 tablet q.i.d. May be increased gradually, as needed, to 3 tablets q.i.d.; with establishment of relief, may be reduced gradually to maintenance levels.

▲Deprol▲®

meprobamate 400 mg.
+ benactyzine 1 mg.

WALLACE LABORATORIES / *Cranbury, N.J.*

CD-9237

KEYED to your profession, DOCTOR.....



COASTAL CAR LEASING GETS YOU THERE!

SELECT THE CAR YOU WANT ■ ANY MAKE, ■ ANY MODEL ■ NO INVESTMENT ■ NO FINANCE CHARGES ■ 100% TAX DEDUCTIBLE EXPENSE ■ ONE FIXED MONTHLY COST INCLUDES MAINTENANCE, REPAIRS, INSURANCE, TIRES, REGISTRATION ■ IMMEDIATE REPLACEMENT

TAILOR-MADE PLANS FOR THE MEDICAL PROFESSION····WRITE OR CALL

COASTAL CAR LEASING

DIVISION OF COASTAL MOTOR LINES

23 JOHN STREET, EAST RUTHERFORD, NEW JERSEY — GE 8-0790



Robaxin®
(methocarbamol, Robins)

U. S. pat. no. 2,770,649

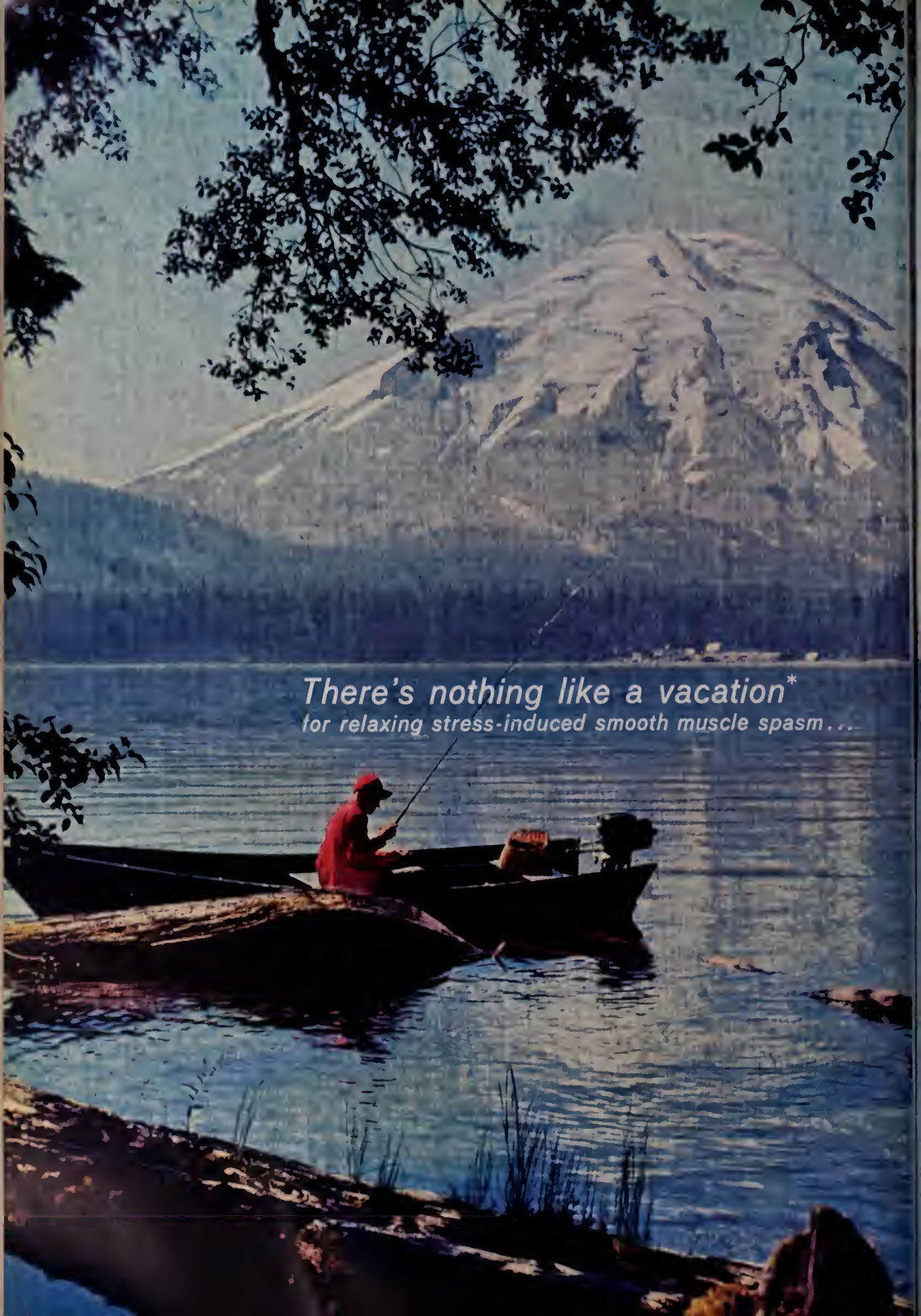
ROBAXIN (methocarbamol) relaxes painful skeletal muscle spasm without impairment of normal muscle strength or neuromuscular function.

Side effects, such as lightheadedness, dizziness, drowsiness, and nausea, may occur rarely, but usually disappear when dosage is reduced. Hypersensitivity reactions have been reported infrequently. Contraindicated in patients hypersensitive to the drug.

Average adult dose

	ROBAXIN® (methocarbamol, 500 mg./tab.)	ROBAXIN®-75 (methocarbamol, 750 mg./tab
Initially	3 tablets q.i.d.	2 tablets q.i.d
Maintenance	2 tablets q.i.d.	1 tablet q.4 h or 2 tablets t.i.d

A. H. ROBINS CO., INC., Richmond 20, Virginia


There's nothing like a vacation*
for relaxing stress-induced smooth muscle spasm...

Outstanding effectiveness in clinical usage—plus freedom from the risk of serious side effects—are the compelling reasons why DONNATAL has maintained its pre-eminent position as a smooth muscle relaxant through the years.

Over 5 billion doses have been administered since its introduction...impressive evidence of professional confidence in the clinically reported benefits provided by DONNATAL:

- excellent results in a wide range of visceral disorders[1-6]
- well tolerated[1-6]
- convenient dosage forms[1,3]
- uniform composition[1,3]
- stability[1,3]
- economy[1,3]

DONNATAL is indicated in recurring, persistent or chronic visceral spasm, as in: peptic ulcer, pylorospasm, irritable stomach and colon, nervous indigestion, dysmenorrhea, nausea of pregnancy, motion sickness, nocturnal enuresis, mucous colitis and diarrhea.

No serious toxic reactions are to be anticipated. Dryness of the mouth, blurred vision, difficult urination, and flushing and dryness of the skin may occur with excessive and prolonged dosage, but promptly disappear with reduction in dosage.

DONNATAL is contraindicated in acute glaucoma, advanced hepatic or renal disease, and known or suspected idiosyncrasy to any of its components. Patients with incipient glaucoma or urinary bladder neck obstruction must be treated with care, as with any preparation containing a parasympathetic depressant.

REFERENCES: **1.** Barden, F.W., Hill, P.S., Mahaney, W.F., and Cuneo, K.J.: J. Maine M.A. 45:11, 1954. **2.** Chaput, Y., and Baillargeon, J.: L'Union med. du Can. 86:205, 1957. 3. Hock, C.W.: Clin. Med. 8:1932, 1961. **4.** Kilstein, R.I.: Rev. Gastroenterol. 14:171, 1947. **5.** Marks, L.: Am. J. Gastroenterol. 27:180, 1957. **6.** Wharton, G.K., Balfour, D.C., Jr., and Osmon, K.L.: Postgrad. Med. 21:406, 1957.

...nothing, that is, except the sedative-antispasmodic action of

Donnatal®

Robins

In each Tablet, Capsule or 5 cc. Elixir		In each Extentab
0.1037 mg.	hyoscyamine sulfate	0.3111 mg.
0.0194 mg.	atropine sulfate	0.0582 mg.
0.0065 mg.	hyoscine hydrobromide	0.0195 mg.
16.2 mg. (¼ gr.)	phenobarbital (¾ gr.)	48.6 mg.

(Warning: May be habit forming)

Prescribed by more physicians than any other antispasmodic—*well over 5 billion doses!*

A. H. ROBINS CO., INC., Richmond 20, Virginia

This one at Spirit Lake, Washington.



Helps speed recovery even in severe muscle injuries

Whether your muscle-injury patient is a professional athlete or just a weekend golfer, you can expect rapid results with 'Soma' (carisoprodol).

This unique drug breaks up both muscle spasm and pain at the same time. Onset of action takes only 30 minutes, and your patient will usually begin to feel better within hours.

As Conant demonstrated in a study of 106 patients with musculoskeletal injuries, 88% of the patients treated with 'Soma' (carisoprodol) achieved good to excellent results. *(Clinical Medicine,* March, 1962.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely.

For severe athletic strains or everyday sprains, you can rely on 'Soma' (carisoprodol) to help speed recovery with notable safety.

USUAL DOSAGE: ONE 350 MG. TABLET Q.I.D.

The muscle relaxant with
an independent pain-relieving action

Soma®
carisoprodol

Wallace Laboratories, Cranbury, New Jersey

blood, milk and Maalox®

(magnesium-aluminum hydroxide gel)

Practically standard treatment, now, for perforated ulcer. Why is Maalox included? Antacid therapy *must* continue long after the wound has healed, and patients started on Maalox tend to stay on Maalox. It tastes good; it's effective and will not cause constipation—three important reasons for Maalox over the long haul. Some physicians, we are told, order Maalox routinely for hospital patients on drugs which could irritate. They feel it reduces the likelihood of gastric discomfort. Supplied: Suspension; Tablets No. 1; Tablets No. 2. (Each Maalox No. 1 Tablet is equivalent to 1 teaspoonful and each Maalox No. 2 Tablet is equivalent to 2 teaspoonfuls of Suspension.)



ROHER
WILLIAM H. RORER, INC., FORT WASHINGTON, PA.



We like visitors. We like to show them our modern equipment and latest research facilities, our exacting manufacturing techniques and unexcelled quality standards. Up to a point, that is. A white line provides the barrier that discourages further exploration. It means look but don't cross. It is a safeguard against inadvertent mishandling or misplacing of products—another precaution in an endless list of rules contributing immeasurably to the quality of the finished product.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

3v0178

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

The Research Piper—and the Research Tune

Medicine has three daughters: Research, Teaching and Practice. And, of these, the most glamorous is Research and the least glamorous is Practice. Everybody loves to teach. But the fair-haired boy is Research. It is at once the fund-attracting magnet of today and the great white hope of tomorrow. It is hard to get any Foundation, University or other angel to donate money for more medication, more equipment, or roomier wards. But if you don't mind filling out a king-sized application book, you stand a good chance of getting money for research.

It is hard to say anything against research —the obvious analogy is being against mothers. Yet something must be said against it. It promises a miracle drug or a miracle method —some day. But the patients need care now and they won't wait for "some day." If research were to drain off our best minds, it would consign patient care to minor leaguers —hardly a defensible position. There is a more subtle difficulty here, too. When we don't know what to do to help a patient, it is easier to say, "let's study the problem more profoundly," than it is to try empirically to help. It seems reasonable to say: "let's study it a little more." But this can be a way of stalling all action. Indeed, it gives its blessing to passivity: we can't do anything now because we haven't thoroughly researched it!

Like most things, research is more glamorous viewed at a distance than it is in close-up. In day-by-day operation, research requires some tears, a lot of sweat, a high frustration tolerance, an ability to submerge one's individuality in a team, a willingness to see a failure rate of 90 per cent or more, and plenty of patience. A century ago, research was the activity of the solitary genius working alone in the attic or cellar—the yield of an astonishing serendipity or the product of a decade of wretchedly hard work. Today, research is a team operation with as much use for a prima donna as a chorus of sailors in *Pinafore*. In many projects, the individual worker sees the total picture only to the extent that the assembly line laborer sees where his bolt fits into the total car.

Published Monthly Since 1904 Henry A. Davidson, M.D., Editor
Under the Direction of the Committee on Publication Theresa E. Goeke, Assistant Editor
George B. Sharbaugh, M.D., Chairman

Place of Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — EXport 4-3154
Send all communications regarding advertising to Joseph W. Cookson, 370 Morris Ave., Trenton 10, New Jersey — EXport 3-7196
Each member of the Society is entitled to receive a copy of The Journal every month

Whole Number of Issues 708

Vol. 60, No. 8 AUGUST, 1963 50 Cents - $5.00 per year

Most research is subsidized. The ones who pay the piper insist on hearing the tune. It is seldom that the paymaster can hand a check to the genius and say "Research wherever you want; follow wherever the path leads." More likely he insists on a protocol in advance, and pays only so long as the road map is being followed. Thus, even sterile research is kept alive by hopeful progress reports. Research teams rarely commit suicide by stopping en route to tell the angel: "We are at a dead end; it would waste your money to continue any further on this path."

By all means, let's bake that pie in the sky. But a little bread here on earth should not be scorned.

Oliver Wendell Holmes—surely no anti-intellectual—once told a Harvard medical class (November 6, 1867): "I pay the captain of the ship to carry me quickly and safely to Liverpool, not to make an Atlantic chart for future voyagers."

Physician's Role in Auto Accident Prevention

According to Dr. Fletcher D. Woodward,* "the medical profession could cut the incidence of auto crashes by 50 per cent right now." In developing this thesis, he makes the following points:

> There is one crash every three seconds (that's right—every three *seconds*, not every three hours). There is, in this country, one automobile death *every ten minutes*, day in and day out, round the clock, twenty-four hours a day! Automobiles have, since 1915, killed more Americans than wars. Alcohol is a mapor factor. The drunken driver, says Dr. Woodward, accounts for a third of the crashes and half of the deaths. Other driver-causes were personal recklessness, immaturity, exhibitionism, fatigue, epilepsy, taking of insulin, emotional disturbances, excessive intake of medications, and cardiovascular disorders.

Dr. Woodward travels a lot—but usually by air. "I'd be scared to take a long trip by car," he says.

When one reviews Dr. Woodward's bill of particulars, the potential role of the physician becomes clear. Do we doctors now take the initiative—or will some other group make these medical decisions?

*In the February 1963 *New Physician.*

Doctors' Handwriting

"Illegible as a prescription" was once a funny phrase. Physicians were supposed to have poor handwriting. Indeed, some doctors boasted of it. But illegibility can be expensive and dangerous. It would be hazardous to read Diphemanil as Diphenadione or to mix up nitrites and nitrates. As for the expense—well Dr. Herman Feldman did a little research on that* and scanned the 120,000 orders written in 1962 in the Gary Methodist Hospital. Let Dr. Feldman take it from here.

"It would take 3200 hours to interpret them, if they were all legible. But if they were harder to read it would take 30,000 hours—and the cost difference would be $48,000. In this study, 40 per cent of all orders were illegible."

One unexpected finding was this. Many doctors write their orders while standing—or even while walking. Learning to sit down as you write will noticeably improve the legibility of your script. Better yet, he suggests, try handprinting the orders and prescriptions. With practice a doctor can do a legibile printing very rapidly.

Of all the preachings that we have had to listen to in the last decade, this would seem to be one of the least important. And yet—by such little things, large troubles may be caused. As Jonathan Swift observed, when he looked at a bit of script, "Whoer writ that, used his hand like a foot."

Let's stop putting our foot in it.

*Detailed in *Hospitals*, February 16, 1963.

CHARLES R. REAM, M.D.

Elizabeth

Pleural Effusions

A Review of Some Basic Facts and Pertinent Clinical Remarks

In this paper, Dr. Ream offers a compact graduate course in the differential and etiologic diagnosis of pleural effusion.

PLEURAL effusion is a common problem in clinical practice. The anatomy of the pleura is well known and can be reviewed in any standard text. Special mention must be made, however, of two anatomic features: the scalene nodes and the nerve supply to the pleura.

THE SCALENE NODES

THE scalene nodes connect with the lymphatic drainage of the mediastinal nodes. These nodes cannot be palpated on physical examination. They lie within a pad of fat just anterior to the scalenus anticus muscle. They are, therefore, a specific anatomic tissue, and the fat pad must be identified precisely for the excision of the fat pad to be meaningful and proper. A biopsy here showing malignancy always means that the malignancy has metastasized.

Drainage of these glands must be understood. The scalene node on the right drains the entire right lung and the left lower lobe. The left scalene node drains the left upper lobe. Both scalene nodes may drain the middle part of the left lung.

SUPPLY OF THE PLEURA

THE nerve supply of the visceral pleura is derived from the vagus and sympathetic through the pulmonary plexus at the hilum of the lung. While visceral pleura has no pain fibers, the parietal pleura has sensitive pain fibers. Parietal pleura innervation is derived from the phrenic, intercostal, vagus, and sympathetic nerves.[7] This is clinically significant as concerns physical diagnosis. The outer rim of the diaphragmatic pleura receives its sensory supply from the lower six intercostal nerves. Epigastric pain or even lower abdominal pain can be caused by inflammation at this site of the diaphragmatic pleura. Pain referred to the neck and shoulder along the trapezius muscle on the same side may originate from the central portion of the diaphragmatic pleura which receives its sensory supply from the phrenic nerve. This takes origin from the third, fourth, and fifth cervical nerves. The pain originating from these two areas of diaphragmatic pleura is associated with hyperesthesia and hyperalgesia over the appropriate dermatomes and this is a distinguishing characteristic.

PHYSIOLOGY OF THE PLEURA

THE pleura has both secretory and absorptive functions. The visceral pleura has secretory function but has little absorptive function. Absorption is almost completely *via* the parietal pleura. A constant exchange of fluid into and

out of the pleural cavity takes place. Under ordinary circumstances, this is so efficient that there is only a thin layer of serous fluid between the visceral and parietal pleura. The fluid is a lubricant and hydraulic seal. The amount of fluid present in the pleural cavity depends on a delicate balance between the visceral pleura transudate from the visceral pleural capillaries and its reabsorption by the parietal pleura venules and lymphatics. Disease processes which disturb this balance can produce a pleural effusion. Infections or an increase in negative intrapleural pressure can disturb this balance. An increase in pulmonary capillary pressure in excess of 35 millimeters of mercury (usually a result of left heart failure) may produce pulmonary edema and pleural effusion. Direct pressure from a neoplasm on the vena cava can raise pressure to the point where fluid develops. Osmotic imbalance as a result of hypoproteinemia occasionally gives rise to considerable pleural effusion.

CLINICAL MANIFESTATIONS

THE clinical manifestations of pleural effusion vary considerably. In general, there is a certain amount of *dyspnea* of which the patient is aware. Some patients can tolerate 2,000 to 3,000 cubic centimeters of fluid with relatively little difficulty whereas others are critically distressed by as little as 500 cubic centimeters.[11] The rapidity with which the effusion forms appears to determine the amount of dyspnea and other distress.

The condition of the lung under the effusion is symptomatically important. A person with a diseased lung can tolerate an effusion much less than can a patient with healthy lung underlying the fluid. Also, a diseased lung on the side opposite an effusion has a great deal to do with the overall symptoms and distress of the patient.

Pain is caused when the pleura rubs together. This occurs when the patient takes a deep inspiration or when he coughs. A friction rub heard at this time leads to a diagnosis of fibrinous pleurisy. At this stage, malaise, weakness, cough, and fever are usually present. As the disease process progresses, fluid separates the visceral and parietal pleura; the pain then disappears as does the rub. The pain may be referred to the abdomen or neck if the diaphragmatic pleura is involved. Pain may be severe and "knifelike" in character. On occasion, it may be a dull aching sensation in the chest. The patient prefers to lie on the side of the effusion. This relieves pain by helping "splint" the chest; and it allows greater expansion of the normal lung.

The classic physical signs of pleural effusion are dullness to flatness and diminished respiratory excursions; breath, and voice sounds; and absent or diminished tactile fremitus. As fluid increases and the lung is compressed, three groups of signs may appear which correspond to the zone of fluid, the zone of collapsed lung, and the zone of normal lung. A sudden change of signs, not infrequent with obstructive atelectasis, does not occur with pleural effusion.

X-RAY FILMS

X-RAY chest films are of great help in determining whether we are dealing with a pleural effusion. Normally there is a surprising depth of the posterior component of the costophrenic sulcus. In patients with emphysema and a depressed diaphragm, this depth may be considerably greater than normal. It takes at least 500 cubic centimeters of fluid just to obliterate the costophrenic angle in normal persons. In patients with a depressed diaphragm (such as we see in emphysema) it may take as much as a liter of fluid before it can be seen to obliterate the costophrenic angle in the postero-anterior chest film.[11]

It may be difficult to recognize minimal pleural effusion on the conventional postero-anterior chest film, and special technics may be needed. These include recumbent films for patients in whom one or both hemidiaphragms appear elevated.[12,13,14] Lateral and oblique views are often helpful.

LOCATION OF EFFUSION

THERE appears to be a great incidence of right-sided (as opposed to left-sided) hydrothorax in congestive heart failure. This well-known clinical fact is frequently first observed by the radiologist.[12] The reason is not clear. It has been theorized that it results from increases both in the pulmonary and systemic venous pressures since venous drainage is both into the superior vena cava and pulmonary veins.

Hydrothorax may result from a combination of both pulmonary and systemic congestion. Bedford [15] believes, however, that the viscereal more than the parietal pleura gives rise to the transudate. This would indicate that the pulmonary more than the systemic circulation is involved when left ventricular failure is primarily present. He makes the observation that conditions associated with left ventricular distress and failure with regular rhythm favor a left-sided effusion, whereas failure associated with fibrillation predispose to a right-sided effusion. In hypertensive heart failure with a regular rhythm, left hydrothorax occurred twice as frequently as right, whereas when atrial fibrillation was present, right hydrothorax was three times as frequent as left.

Dock [17] has an interesting explanation for right-sided pleural effusion associated with congestive heart failure. We know that patients in heart failure prefer to lie on their right sides. Venous blood in the lung must eventually return to the left ventricle which has its center of mass near the ventral chest surfaces and the diaphragm slightly to the left of the midline. Gravity raises the venous pressure of this flow 20 to 30 millimeters of water greater than at the apex of the heart when the patient is in the upright position. In the cardiac patient in failure (who lies in the right recumbent position) the venous pressure in the lateral and basal segments of the right lung is 10 to 20 millimeters of water higher than in any other part of the left lung. Since tissue fluid increases rapidly with increasing venous pressure, a right-sided effusion forms.[18]

Gray and Field [19] make some interesting observations concerning fluid interchange at the pulmonary capillary wall in lung edema. In chronic passive congestion of the lung, alveolar edema and transudation in the visceral pleura probably proceed together. When right-sided heart failure supervenes, the enormous transuding surface of the parietal pleura (perfused by systemic capillaries) contributes to massive pleural effusion. It is difficult to see why pleural effusion is not more common in acute pulmonary edema. The intrapleural pressure is more negative in relation to the atmosphere than the intra-alveolar pressure; hence with acute increases in capillary pressure, there should be a great outflow of fluid from the visceral pleura. Possibly the lymphatics in the pleura protect it in contrast to the alveoli where no lymphatics are present, or possibly in acute pulmonary edema, reflexes impair the permeability of the alveolar-capillary membrane, but not the pleural capillary wall.

CLINICAL CHARACTER OF EDEMA

THE clinical character of edema is more dependent on the cause and factors leading up to alteration of the capillary fluid interchange than it is on local phenomena. Thus, acute pulmonary edema is a rapid neurogenic phenomenon with a receptor organ, afferent pathways, central connections, and efferent pathways. It includes effector and supressor systems. Chronic passive congestion is a more gradual response to left heart failure.

At the capillary level, edema accumulation, regardless of the cause of initiating pattern, is related to a change in the balance of net hydrostatic and osmotic pressures, membrane diffusion and lymphatic drainage, and the volume of circulating water and electrolytes.

The phantom (or "vanishing") tumor should be mentioned here. This is a localized interlobar effusion and is found most commonly in the horizontal fissure. When the heart failure is treated and compensation restored, the effusion disappears. It is mentioned here because the radiologist usually is the first to

observe it. It is easily confused with pulmonary neoplasm.

Loculated effusions on the right may be difficult to diagnose because of the presence of the middle lobe. The differentiation between middle lobe collapse, interlobar effusion or both presents problems. Lateral x-ray films and, on occasion, tomography and bronchoscopy become necessary for accurate diagnosis.

TRANSUDATES, EXUDATES AND THORACENTESIS

WHEN it has been decided that a pleural effusion exists, the next step is to do a thoracentesis to determine what type of fluid one is dealing with, provided of course that this is clinically indicated. (In heart failure, it may not necessarily be indicated.)

Primarily we are concerned with the question, "Is the fluid a transudate or an exudate?"

A *transudate* is any substance which has passed through a membrane. Its specific gravity is less than 1.015; its protein content is less than three Grams per cent. A transudate will not clot; it contains a few lymphocytes; but red blood cells and fixed tissue cells are rare. Transudates are most commonly found in congestive heart failure, acute or chronic nephritis, cirrhosis of the liver, and lymphatic obstruction caused by tumor.

An *exudate* is any adventitious substance deposited in or on a tissue by a vital process or disease. Its specific gravity is 1.015 or above; its protein content is above three Grams per cent. It contains many white cells and it may even contain pus. An exudate's red cell count may vary from few to many. Its fixed tissue cells are variable. The glucose content is decreased frequently because of glycolysis.

Chest aspiration is not an inocuous procedure. It is not the purpose of this paper to discuss the technic involved; however, a few remarks need be made concerning pleural shock. Experienced clinicians have noticed at one time or another during a thoracentesis that the patient's cardiac and respiratory rate decrease markedly. Some patients may experience more than this. Some may suffer a complete collapse of blood pressure and go into fatal shock. Fortunately, this does not happen often. The degree of shock is roughly a function of the amount and rapidity with which the fluid is removed.

As far back as 1907, Capps and Lewis[20] in animal experimentation demonstrated that an inflammed visceral pleura is very sensitive to stimulation in contrast to the normal visceral pleura. They showed that two reflexes were involved when such a diseased visceral pleura was stimulated. The less serious and more common reflex is cardio-inhibitory and slows the heart rate and respiration. The other reflex is far more serious and, on occasion, may cause death. This reflex is manifested by blood pressure drop and shock.

It therefore appears that stimulation to an inflammed visceral pleura or injury to underlying pulmonary tissue are the factors that cause pleural shock. Another explanation for pleural shock (which used to be a popular hypothesis) was shock on the basis of an air embolism.[21] Unquestionably, air embolism *can* be a cause of shock during thoracentesis on some occasions. Today we do not consider it a major cause of shock occurring during chest tap. Most modern experts favor the theories of Capps and Lewis.

FATE OF A PLEURAL EFFUSION

WHAT will happen to a pleural effusion if it is left alone? This depends upon its etiology, quantity, character and whether it is a transudate, exudate, or gross blood; and upon the condition of the pleura. The mechanism and pathway of pleural fluid absorption have been thoroughly worked out.[8,9,10] The mediastinal and costal pleura absorb colloids and particulate matter. The diaphragmatic pleura is *not* involved with the absorption of pleural effusion. It seems likely that it passes through the cells of the pleural membrane directly or perhaps through "pores" between the cells. After passage through the pleural membrane, colloids reach the blood stream by way of the left and right lymphatic ducts. Foreign matter

is filtered out by macrophages in the lymphatics and nodes.

Wilson *et al.*[22] have demonstrated that a massive hemothorax can be rapidly and completely absorbed from the normal pleural space in dogs and that the red cells are restored intact to the peripheral circulation. This also occurs in humans. Its clinical significance is apparent.

In the presence of an exudate, thickening and fibrosis of the pleura prevent absorption. Before fluid can be reabsorbed, thick exudates must become liquefied and the obstructed lymphatics must become patent.

Exudates require treatment directed at the chest and its contents *per se*. The mechanisms of how an exudate forms were previously considered. An empyema is an accumulation of pus in the chest. It is a serious form of an exudate, as the fluid may consist entirely of frank pus. The pus may be confined by adhesions to several localized areas and would then be considered as multiple abscesses within the chest. There is no serous fluid in an empyema and because of the adhesions, it does not lie free in the pleural space. It can develop in the following five ways:

(A) By contamination when a thoracentesis is done improperly.

(B) By chest trauma.

(C) Lymphatic drainage of bacteria into a sterile effusion or by a bacteremia.

(D) Direct extension from underlying lung disease or extension of infection into the pleural space from any structures in contact with the pleura. (Ribs, mediastinum, subdiaphragmatic space).

(E) Septic infarctions of the lung.

If an empyema is present, no absorption will take place. On occasion, if left untreated, pus makes a spontaneous escape through the chest wall. This is called *empyema necessitatis*. It may also escape by extension through the lung into a bronchus.

Treatment of empyema is both medical and surgical. Streptokinase and streptodornase with aspiration are often of considerable use in small, localized empyema.[23] The after effects of empyema are usually devastating on pulmonary function, and decortication is often necessary in order to restore lung function.

PLEURAL BIOPSY

AT THE time of thoracentesis, a needle pleural biopsy can be done. The procedure is simple [24] and the results are often rewarding in terms of understanding the etiology of the effusion.[25] Open pleural biopsy is also easily done and is indicated when the needle biopsy is not helpful. Recently Lewis and Cugell [26] introduced a method of blunt end needle biopsy of pleura and rib using a Cope needle.

HEMORRHAGIC PLEURAL EFFUSION

A PLEURAL effusion containing 1,000 to 3,000 red blood cells per cubic millimeter causes no appreciable change in the color of the fluid. If the fluid contains 5,000 to 6,000 red blood cells it takes on a rosy tint.[27] When an effusion is caused by neoplasm, tumor cells are found almost as frequently in the serous as the hemorrhagic fluid. Hemorrhagic effusions may occur commonly in pulmonary infarctions, malignancies, leukemia, spontaneous pneumothorax, rupture of an aortic aneurysm, and of course trauma to the chest. Less frequently, they occur in pneumonia, tuberculosis, and diffuse lupus erythematosus.

TUBERCULOUS PLEURAL EFFUSION

IT IS one of the well-established conventions of medical practice that pleural effusion of unknown cause is usually tuberculous. If these patients are thoroughly "worked up," frank tuberculosis (pulmonary, extra-pulmonary) will be demonstrated in most of them within five years. Furthermore, these patients cannot be considered as "throughly worked up" until a Lupus preparation has been done and

until one or more pleural biopsies have been performed. In such effusions, pleural biopsy may be rewarding.[24,25,26] It is also in such cases that open pleural biopsy should be considered when the needle biopsy is not helpful.

Tuberculous effusions have certain characteristics. The protein[28] is more than three Grams per hundred milliliters. Usually the tuberculous effusion contains a high proportion of lymphocytes. Though not itself diagnostic, it is in keeping with tuberculosis. However, in the early stages of a tuberculous effusion, polymorphonuclear cells predominate. The glucose level of the tuberculous effusion is usually under 60 milligrams per 100 milliliters. However, low glucose levels have also been described[29] in patients with rheumatoid arthritis and effusion.[30] One should not expect to culture a tuberculous organism from pleural fluid unless at least 500 cubic centimeters of fluid are sent to the laboratory for concentration and then culture. This is a most important procedure. It is, of course, essential that all patients with such effusions have a Mantoux test performed.

PLEURAL EFFUSION IN ABDOMINAL DISEASE

Several articles[5] have appeared recently concerning pleural effusion and pancreatitis.[31] The lymphatic drainage from the abdomen to the chest has been discussed. Dumont *et al.*[32] have shown that stimulation of the pancreas causes the discharge of pancreatic enzymes into the thoracic duct lymph. Fishbein and his co-workers[31] suggest that a transmural migration of pancreatic fluid from the thoracic duct occurs which causes a sterile chemical inflammation which then allows permeation of the parietal pleura.

There are some distinguishing characteristics of pleural effusion resulting from pancreatitis.[33] *First,* the effusion is almost always on the left side. *Second,* the amylase level of the pleural effusion is considerably higher than the amylase in the serum and tends to remain high even when the serum amylase begins to return to normal. Thus, amylase determination of pleural effusion of unknown etiology might be of great importance.

Empyema in the right chest can be a manifestation of subdiaphragmatic abscess and liver abscess (particularly amebic).

CHYLOUS AND CHYLIFEROUS PLEURAL EFFUSIONS

Chylous pleural effusion results when the thoracic duct, its tributaries or the left subclavian vein is obstructed. Neoplasm is the usual cause of this although, on occasion, trauma is involved. There have been reports of spontaneous rupture, but this is certainly rare. The duct lies outside the pleural cavity and for this reason there may be a considerable accumulation of chyle within the mediastinum before rupture into the pleural space.

Pseudochyle may resemble chyle in its physical appearance. It results from fatty degeneration of pus and endothelial cells and is seen in long-standing pleural effusions that have been encysted. The laboratory will help establish the differentiation. Chyle is milky white and apolescent; after standing, a creamy layer develops much as does cream on a bottle of unhomogenized milk. It has a high fat content and the fat globules are easily demonstrated with Sudan III. The specific gravity is greater than 1.012, and it contains a variable quantity of protein. Chyle does not clot nor does the fluid putrefy. The cell content is predominately lymphocytic as would be expected. Pseudochyle has no fat globules and (in contrast to chyle) is not usually sterile.[34]

MEIGS' SYNDROME

Meigs' syndrome exists when the patient has a benign tumor of the ovary,[6] usually a fibroma[35] with ascites and a hydrothorax.[36] After removal of the tumor, both the ascites and hydrothorax disappear. The hydrothorax

is a transudate but on some occasions the fluid is bloody. This bloody fluid has been reported to be on the basis of torsion or trauma.[37] The important point is that an ovarian tumor accompanied by ascites and hydrothorax (and even by a bloody hydrothorax) does not necessarily mean that the patient has malignant disease.

How does this fluid get into the chest? It is probably on the same basis as has been described previously concerning ascites in Laennec's cirrhosis. Another explanation[38] is that a congenital opening in the diaphragm might be present in some cases. The former explanation, however, is considered the more likely in most situations.

SENSITIVITY AND PLEURAL EFFUSION

IN DRUG allergy and in certain parasitic pulmonary disease, an eosinophilia of both transient and chronic nature has been observed. Many drugs have been reported to be the cause of pulmonary lesions, diffuse pulmonary fibrosis, and pulmonary infiltrations with eosinophilia. Hydrolazin, Nutrofurantoin,[39] mecamylamine, paraminosalicylic acid, penicillin, mephenesin carbamate, and vaginal cream containing sulfonamides have been so implicated. It is, therefore, wise to question a patient carefully for a possible connection between a drug and a sensitive patient when dealing with a pleural effusion that cannot readily be explained.

The St. Elizabeth Hospital

A bibliographic list of 39 citations appears in Dr. Ream's reprints.

Use of AMA Name in Contact Lens Sales

The company making "Vent-Air" contact lenses sent out brochures which implied AMA-endorsement of its product. The National Medical Foundation for Eye Care sent the pamphlet to the AMA. The AMA acted to protect its name. The Law Department sent the following letter to the Vent-Air Contact Lens Company:

"A pamphlet dealing with Vent-Air Lenses bearing on its lead page the statement 'What does the medical profession think about Vent-Air lenses?' copyright 1957 by the Vent-Air Contact Lens Laboratories, New York, has been brought to the attention of the Law Department. On the lead page under the heading mentioned is the following statement:

'Both the American Medical Association and the optical profession have accorded special recognition to the remarkable advance represented by Vent-Air Contact Lenses.'

"The American Medical Association has a property right in its name and the use thereof. The AMA does not approve, endorse, or accept any commercial products. We have no record in our files of granting permission to your company to use our name in such a manner . . .

"We must request, therefore, that you cease making any further reference to the American Medical Association in connection with Vent-Air Contact Lenses or any other product. We would further request that you cease distribution of this or any other pamphlet or publication bearing the name of the American Medical Association in this connection and without our specific written permission.

"We would appreciate your informing us of your compliance with these requests."

On February 22, 1963, the Federal Trade Commission issued a consent order against Klear Vision Contact Lens Specialists, Inc., prohibiting certain false advertising of Vent-Air contact lenses.

Joseph F. Lutz, M.D.

Livingston

Endotracheal Anesthesia: The Choice for Adenotonsillectomy*

Dr. Lutz presents evidence indicating that endotracheal anesthesia is the method of choice for tonsil surgery in children. The alleged drawbacks are, however, frankly reviewed.

In the past few years articles[1] have appeared in both medical and lay publications cautioning against the frequency of adenotonsillectomy in children.[2] One reason given is that, occasionally, the patient dies during or soon after the operation. This certainly concerns us as anesthesiologists in making sure our technics are the safest possible. Also, the experience of a visit to the operating room for the crying child with its resultant high proportion of bad personality changes[3] behooves our conducting the child's course of anesthesia (including pre-operative preparation) in a well-sedated and smooth manner. As part of such a program an oral endotracheal tube is recommended. The original stimuli to this procedure were: requests from surgeons or consultants or the anesthetist's inclination to use a tube in cases such as in patients with rheumatic heart disease, cerebral palsy, mongoloids, extremely obese children, or those who had respiratory emergencies during previous surgery. If breath-holding, twitching and convulsions,[4] aspiration of vomitus and blood, laryngospasm with hypoxia, and long recovery periods were to be avoided in such patients why not try to avoid them in all and take over control of vital functions? This, plus having to stop in the middle of an occasional case with respiratory difficulty, to pass an endotracheal tube, makes one regret not having had one there in the first place.

The most dramatic change in the anesthetic management of tonsillectomy came with the use of the nonflammable inhalation agent, Fluothane® (2-bromo-2-chloro-1:1:1-trifluoroethane). Because of its small margin of safety its dosage must be controlled carefully. Since it is expensive and should not be wasted, open drop or insufflation technics are not practical. Anticipating the use of a tube and Fluothane† we may order safely heavy doses of pre-medication not fearing medullary depression since respirations may be aided by compression of the reservoir bag during surgery. A moderate drop in blood pressure, if it does occur, would be favorable in a potentially bloody operation. Uptake of an agent by open drop or insufflation would be impeded by any respiratory depression. Demerol® is preferred to morphine because it does not depress the cough reflex and scopolamine to atropine mainly because of its amnesic effect. Scopolamine is also a better drying agent and has less tendency to cause an increase in pulse rate. For example, an average healthy five-year old weighing

*Read May 16, 1961, at the Annual Meeting of The Medical Society of New Jersey.

†Fluothane® is an Ayerst trade-name for a brand of halothane. Chemically, this is a bromo-chloro-trifluoro-ethane.

‡We used the Abbott brand of pentobarbital which is trade-named Nembutal®. For the lidocaine jelly, we used the Astra brand, trade-named Xylocaine®.

about 45 pounds would receive an elixir of pentobarbital‡ 60 milligrams by mouth one and one-half hours before and Demerol® 50 milligrams plus scopolamine 0.3 milligram, one hour before surgery.

Children so pre-medicated will be asleep on reaching the operating room and will not remember leaving the pediatric ward. Hospital personnel should not disturb these patients on the way to the operating room, in elevators or hallways. This pre-medication compares to rectal basal narcosis which, however, is time-consuming for the anesthetist, requires a prior enema, is fought by many children and causes prolonged postoperative sleep.

FLUOTHANE† has the ability to obtund laryngotracheal sensations [5] and relax jaw muscles quickly, eliminating the need for muscle relaxants. Avoid depolarizing agents such as succinylcholine chloride for jaw relaxation because of the incapacitating muscle pains which often follow the use of such drugs.[6] This pain (mostly in thigh and arm muscles) is frequently the main complaint following the use of succinylcholine in procedures where the patient is ambulatory shortly postoperatively.

Since induction is fast and emergence from anesthesia just as rapid, several endotracheal tubes of different sizes should be at hand so that if the tube first selected is not of the right caliber no time is wasted in substitution. The tube is lubricated with 2 per cent lidocaine‡ jelly and intubation done within three minutes. During surgery 0.3 per cent to 1.5 per cent Fluothane† is the amount delivered. It has been shown [7] that diethyl ether anesthesia can be maintained with lower blood levels of an agent when the trachea is intubated as compared to those not intubated. The respiratory rate in these childen is less than that of the unintubated, due both to the pre-medication and to better carbon dioxide elimination through the clear airway.

Following surgery an aspirating catheter is passed through the tube only if there is suspicion that blood or mucus is in the trachea. This is usually not necessary, not only because of the presence of the tube itself, but because of adequate suctioning by the assistant or by the anesthetist who has a free hand. Collins and Granatelli [8] found blood in the trachea of 100 per cent of their cases where standard insufflation technics were used but in only five per cent of the intubated cases was there any sign of blood in the trachea. The patient is arousable (usually within a short time) but remains quiet due to the pre-medication. Vomiting is rare after Fluothane.†

Objections in the past to the endotracheal method have been these: (1) Will the tube not be in the way of the operator? (2) Doesn't the tube cause erosion of the larynx with subsequent granuloma formation? (3) Won't a tube cause sub-glottic edema and perhaps a respiratory emergency postoperatively? (4) How about the possibility of chipping or dislodging teeth with the laryngoscope blade? and the difficulty of putting an endotracheal tube in place in certain cases?

Is the tube in the way of the operator? If the tube is not too long and does not buckle (but allows the metal connecting piece to rest on the extreme side of the mouth) the tube itself will remain embedded in the bucco-lingual space. The Cole tube (designed to prevent intubation of the right bronchus) which is much wider above the part that enters the glottis should *not* be used as it takes up twice as much space in the mouth as the ordinary tube. A tube placed correctly should not be a hindrance. It contributes to a quieter operating field.

As to granuloma formation, following contact ulceration at the tip of the vocal process of the arytenoid cartilage: This area, to be sure, is the primary site of granulomas of the larynx with no history of intubation. These vocal processes are constantly hammering at each other normally during speaking and straining and have only a thin mucoperichondrial covering which is easily abrased. No wonder that it is not necessary for a tube to be present in the larynx for a contact ulcer to form. In fact, Jackson [9] in reports of 293 case found *none to be related to endotracheal anesthesia*. Barton [10] points out that a flexible endotracheal tube (compared to a rigid bronchoscope) naturally gravitates along the pos-

terior commissure between the vocal processes and recommends hyperextension of the head and smaller tubes as measures to keep the tube from fitting snugly posteriorly and exerting pressure against the vocal processes.

Unangst and Dumke [11] did mirror laryngoscopy prior to 1306 endotracheal anesthesias for adeno-tonsillectomy in children; and again the examination of the larynx was conducted seven to 14 days postoperatively. Two children developed small granulomatous lesions which disappeared on vocal rest within four weeks. But 1304 larynges were normal and Unangst [11] believes the safety factors involved recommend the use of an endotracheal tube since the two laryngeal sequelae in these cases were benign.

Tubes cleaned immediately after use by brushing inside and out with pHisoHex (Winthrop) for two minutes failed to grow organisms when cultured in this laboratory (Orange Memorial Hospital). Smith and Howland [12] reported good results with only one minute of cleansing with pHisoHex®. Such tubes kept clean and placed carefully in the larynx should make the incidence of subglottic edema. *nil.*

As to damaging or dislodging teeth: Many children arrive in the operating room with loose teeth. A straight laryngoscope blade (if kept from touching the teeth by correct handling) prevents dental trauma.

Children, as a rule, are easier to intubate than adults. Their muscular immaturity, in general, enables us to overcome jaw resistance in most cases. The glottic opening lies more cephalad in small children and is easier to reach. Since the narrowest area of the respiratory tract in some children is at the cricoid ring, a smaller tube than fits through the glottis may be needed.

Finally it should be emphasized that it is the skill of the anesthesiologist that matters in these cases. Only an efficient, well-trained anesthesiologist should be used. It seems likely that some inept exhibitions by those learning laryngoscopy and intubation have discouraged many surgeons from the endotracheal method.

4 Ross Road

BIBLIOGRAPHY

1. Bakwin, H.: Journal of Pediatrics, 52:339 (1958).

2. Kaiser, A. D.: The Tonsil and Adenoid Problem. Brennemann's Practice of Pediatrics, 2:40: 1-21, 1960. Published by W. F. Prior Co., Inc., Hagerstown, Md.

3. Eckenhoff, J. E.: Am. J. Dis. Child., 86:587 (Nov. 1953).

4. Di Giovanni, A. J. and Dripps, R. D.: Anesthesiology, 17:353 (Mar. 1956).

5. Stephen, C. R., Grosskreutz, D. C., Lawrence, J. H. A., Fabian, L. W., Burgeois-Gavardin, M. and Coughlin, J.: Anaesth. Soc. J., 4:246 (July 1957).

6. Churchill-Davidson, H. C.: British Medical Journal, 1:74 (Jan. 9, 1954).

7. Mackenzie, A., Pask, C. A. and Robson, J. G.: British Journal of Anesthesiology, 26:111 (1954).

8. Collins, V. and Granatelli, A.: Journal of the American Medical Association, 161:5 (1956).

9. Jackson, C.: Ann. Otol. Rhin. & Laryng., 37:227 (Mar. 1928).

10. Barton, R. T.: New England Journal of Medicine, 248:1097 (June 25, 1953).

11. Unangst, W. and Dumke, P.: Data to be published.

12. Smith, J. R. and Howland, W. S.: Journal of the American Medical Association, 169:343 (1959).

Death Certificates: A Doctor's Responsibility

The New Jersey Board of Mortuary Science reports that undertakers sometimes have difficulty winning the cooperation of physicians in signing death certificates. Delay in signing the certificate complicates the funeral doctor's problems, retards interment, and causes embarrassment to the family. It takes only a few minutes to make out and sign the certificate. It is a duty that the M.D. cannot delegate.

Donald R. Reisfield, M.D.

New Brunswick

Vasa Previa*

The cord blood vessels rarely present in front of the head. But when they do, there may be serious trouble.

Vasa previa is a serious but uncommon complication of pregnancy. Wrisberg [1] first recorded a case in 1773. Since that time fewer than 100 cases have been cited. Israel [2] recently reported the first occurrence of vasa previa in dichorionic twins.

The purpose of this communication is fourfold: to present a delivery complicated by vasa previa; to call attention to vasa previa as a complication frequently misdiagnosed; to emphasize the association between painless bleeding in early pregnancy and complications of placentation which become manifest at delivery; and to point out that it *is* possible to diagnose this prior to delivery by appropriate testing.

Turnbull and Walker [3] have reported the association of bleeding prior to the 28th week of gestation with increased perinatal loss, prematurity and perhaps even fetal abnormalities. Thompson and Lein[4] studied 404 pregnant patients who reported early bleeding but failed to abort. They showed a 16 per cent incidence of prematurity contrasted to 10 per cent in a control group. They also reported a fourfold increase in neonatal mortality and twofold elevation in perinatal mortality in premature infants along with a sixfold rise in neonatal mortality and fourfold increase in perinatal mortality in term infants born to mothers who experienced vaginal bleeding in the first 120 days of gestation. When the etiology of fetal death could be determined there was no evident cause and effect relationship between early bleeding and perinatal death.

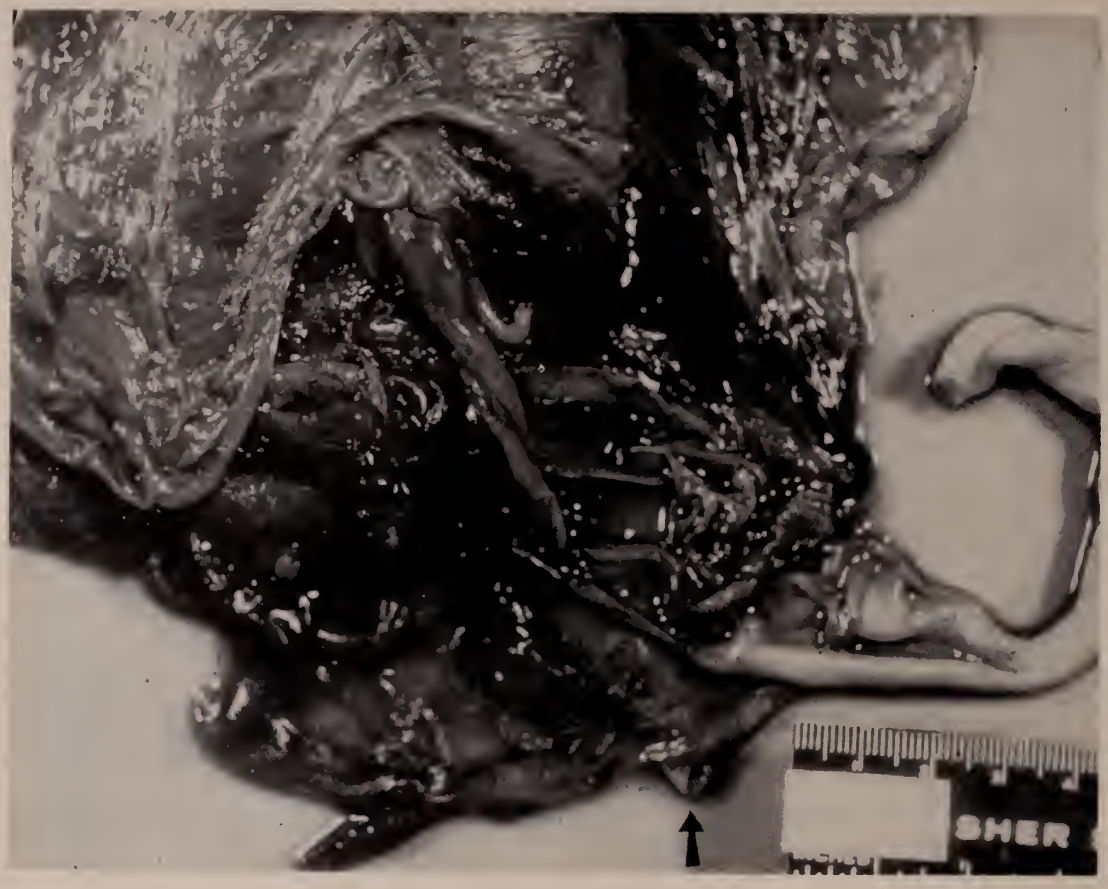
Nesbitt [5] has indicated an association between circumvallate placenta and antepartum bleeding. Thompson and Lein [4] in their series of early gestational bleeding reported an elevated seven per cent incidence of circumvallate placenta. The association of velamentous insertion of the cord and early bleeding is less clear. Origin of the umbilical cord vessels in the amnion at some distance from the placental margin, or velamentous cord insertion, is, of course, a prerequisite for vasa previa. The conditions for vasa previa are met when the umbilical vessels traverse the amnion in the region of the cervical os.

Anatomically, it is evident that such a situation is fraught with danger. Torrey [6] reported a 60 per cent perinatal mortality associated with vasa previa.

To reduce this extremely high fetal mortality an awareness of this condition is imperative. Differentiation from abruptio placenta, placenta previa and marginal sinus rupture is necessary, and requires a high index of suspicion.

Previous placentography or radioactive sodium placental localization may have been done for midtrimester bleeding and visualized a normally implanted placenta. If this documenta-

*This work is from St. Peter's Hospital, New Brunswick, N. J.



The fetal vessels traverse the amnion for four centimeters before the placental margin is reached. The right margin of the specimen covered the region of the cervical os. The arrow indicates the site of vessel rupture during delivery. No other site of vessel rupture to explain the predelivery bleeding was noted.

tion has not been obtained, a gentle vaginal examination under double setup precaution should be performed. Theoretically, it is possible to palpate pulsating vessels coursing over the presenting part. The absence of pulsations does not rule out vasa previa.

An obvious abruption is not difficult to differentiate. However, lesser degrees, unassociated with clotting defects and uterine pain, present a problem. In this instance the blood lost both externally and retroplacentally is insufficient to bring about maternal pulse or blood pressure changes. Bleeding from vasa previa is fetal in origin, and does not alter maternal hemodynamics. The fetal heart rate can increase. However this could indicate fetal distress from any number of causes.

Clinical differentiation from marginal sinus rupture is difficult. Although, generally painless, rupture of the marginal sinus is often accompanied by a dull lower abdomen pain[7] frequently just preceding the bleeding. It is estimated[7] that 40 per cent of third trimester bleeding results from marginal sinus rupture. In a third of the cases, the hemorrhage is concealed and not noted until after delivery. In half of the cases, labor ensues within 24 hours. The incidence of prematurity is very high.

One method which may help in diagnosis is the determination of whether the hemorrhage is fetal or maternal in origin. Electrophoresis differentiates these forms of hemoglobin, but is impractical. The Apt test is simple, requires only a few milliliters of blood, and can be done on the delivery floor. Differentiation is based on the resistance of fetal hemoglobin to con-

version to alkaline heme, upon the addition of sodium hydroxide. Maternal hemoglobin upon addition of alkali will convert from a pink to a yellow color, whereas fetal hemoglobin retains its pink coloring.

A 24-year old nullipara was seen 6½ months before expected date of delivery. The first 5 years of her marriage were childless. Medical advice had not been sought to determine the cause of this barrenness. Her general health had always been good except for recent allergic rhinitis and sinusitis. Menstrual history was unremarkable. The last normal period had been on October 23. Scant brown staining had been observed for three days in the beginning of December.

The thyroid was not palpable. Breasts were moderately full; the labia majora slightly hypertrophied, and the clitoris normal in size. Clear, viscous secretion was seen in the cervical os. The uterus was enlarged to 10 weeks' size. The pelvis was clinically typed as adequate gynecoid. Urine analysis and hemogram were normal. We found a negative serology and survey chest film, and A-negative blood type.

The antepartum course was marked by episodes of painless vaginal bleeding commencing about one month after the patient was initially seen. On February 2, speculum examination indicated progressive uterine growth. She was started on norethynodrel 10 milligrams per day, and vaginal bleeding ceased on February 10. Norethynodrel was discontinued on March 1. Although intercourse had been interdicted at the expected time of the first three menstrual periods, the patient reported that throughout the subsequent course of pregnancy intercourse was followed by one day of light brown staining.

At 34 weeks gestation, the patient was admitted to the labor floor with a history of four hours of irregular contractions. Noticeable but minimal vaginal bleeding was present. The cervix was now moderately soft, partly effaced and one finger dilated. The presenting part was high, and no placenta was felt. The patient was given 75 milligrams of pethidine and started on lututrin (tablets 6) in an attempt to inhibit labor. Lututrin (tablets 4) was repeated in one hour. However, 35 minutes after this dose, strong, rapid uterine contractions commenced accompanied by increased vaginal bleeding. Twenty-five minutes later a 57-ounce baby boy (Apgar score 6) was spontaneously delivered under cyclopropane anesthesia. The infant responded to routine resuscitative measures.

The significance of making a diagnosis of vasa previa lies in the differentiation from lesser degrees of placenta previa, abruptio placenta and marginal sinus rupture. The latter conditions can lead to severe maternal hemorrhage; but vasa previa is associated only with fetal blood loss. Whereas, management in placenta previa, abruptio placenta and marginal sinus rupture generally includes artificial rupture of the membranes (dependent on cervical dilatation and placental location); *amniotomy is contraindicated in vasa previa.* Rupture of the membranes in this condition is extremely perilous as the vessels traversing the the amnion may be torn. As soon as the diagnosis is established, delivery should immediately be effected.

That bleeding somewhat heavier than normal was encountered raised the question of a low-lying placenta. Gentle pelvic examination revealed that the vertex filled the lower uterine segment. No pulsations were felt. Since we were dealing with prematurity the question of a marginal sinus rupture arose. One-half of newborns in marginal sinus rupture are premature.[7] Early pregnancy bleeding of unknown etiology (which this patient manifested) is not particularly associated with marginal sinus rupture. However, the prematurity led to the conservative approach of sedation and institution of measures to forestall labor. Once active labor became established progress was rapid. Progression from 20 millimeters to full dilation took less than 30 minutes. With delivery the vertex was seen covered by the membranes. Fetal vessels were seen traversing the membranes in front of the head. These vessels were severed and seen to be bleeding. With the diagnosis apparent the cord was rapidly clamped. Subsequent examination failed to reveal an obvious site to account for the predelivery bleeding. It was postulated that the bleeding arose from the rupture of a small vein coursing through the amnion.

The infant's blood status was clouded by a bilirubin of 20 milligrams per cent reached on the third day following delivery. However, serial hemoglobins and hematocrits were within normal limits, and gave no indication of fetal hemorrhage. The infant's stool was negative for fetal hemoglobin which was determined[8] in an attempt to detect bleeding into the amniotic cavity.

SUMMARY AND CONCLUSIONS

1. A pregnancy complicated by vasa previa with fetal survival is presented.

2. Clinical and laboratory differentiation of vasa previa from placenta previa, abruptio placenta and marginal sinus rupture is necessary—and discussed.

3. An association between early gestational painless bleeding of unknown etiology and placental complications manifest at delivery is emphasized.

148 Livingston Avenue

BIBLIOGRAPHY

1. Wrisberg, H.: Bulletin of the Royal Society of Gottingen, 4:63 (1773). Quoted by Beer in Surgery, Gynecology and Obstetrics, 3:595 (1954).

2. Israel, R.: Obstetrics and Gynecology, 17:691 (1961).

3. Turnbull, E. and Walker, J.: Journal of Obstetrics and Gynecology of the British Empire, 63:553 (1956).

4. Thompson, J. and Lein, W.: Journal of Obstetrics and Gynecology, 18:40 (1961).

5. Nesbitt R.: *Perinatal Loss in Modern Obstetrics*, Philadelphia, 1957. F. A. Davis Company.

6. Torrey, E.: American Journal of Obstetrics and Gynecology, 63:146 (1952).

7. Fish, J.: Clinical Obstetrics and Gynecology, 3:599 (1960).

8. Apt, B. and Downey, W.: American Journal of Diseases of Children, 86:639 (1953).

Health Check-Ups Pay Off

Cancer detection examinations "pay off," according to *Patterns of Disease*, a Parke, Davis & Company publication for doctors. "It has been suggested that annual cervical cell examinations might enable the physician practically to eliminate cervical cancer as a cause of death of females," *Patterns* reports. Survival rates when cancer was found by detection examinations *before* symptoms appeared were 100 per cent better than the standard five-year survival rates.

Only 44 of 269 apparently well persons who underwent a periodic health checkup were free from disorders "considered hazardous to health or capable of interfering with effective function." Two-thirds of the disorders so found were previously unknown to the patients.

In the study of 269 "apparently well" patients, the largest number of disorders revealed by periodic health checkups were gastrointestinal, found in 117 patients; followed by cardiovascular and genitourinary disorders.

Two-thirds of the executives given health examinations complied with recommendations for therapy or further diagnostic study. Compliance was higher among younger patients.

Among "healthy" middle-aged men, about two of every 100 have undetected coronary disease, according to *Patterns*.

Tomorrow's Miracle Drug

Whether it be in electronics or in drugs, modern research requires enormous sums of money spent with considerable boldness; there are more research efforts that fail than succeed. Good public policy is that which encourages men to search for new things from which all society will profit. Before we wreck the patent system, we might ask whether it is better that somebody have a "monopoly" on tomorrow's miracle drug than that the miracle lie undiscovered.—Editorial, *Wall Street Journal*.

Joseph A. Fleming, M.D.

Montclair

Prevention of Fetal Loss in Pre-Clinical Diabetes

Almost 100 per cent fetal salvage was achieved when insulin was given to previous aborters who had positive glucose tolerance curves. Those with negative tests showed 90 per cent fetal loss.

Overt diabetes mellitus is one of the major causes of fetal loss. Studies have also demonstrated a relatively high incidence of fetal loss in pre-clinical diabetes. This encompasses a group of symptom-free patients who manifest an abnormal provocative glucose tolerance test subsequent to having had consecutive spontaneous abortions.

REVIEW OF THE LITERATURE

Wilkerson, in a study of 14,988 pregnant women, found 478 with a positive glucose tolerance test. Then 208 of the "glucose tolerance positive" group were treated with insulin; and 212 patients were denied insulin therapy. A group of 209 patients with *normal* glucose tolerance curves, selected at random, were used as negative controls. The negative controls and the insulin treated groups had statistically similar fetal outcomes; whereas the untreated positive glucose tolerance groups had a much higher incidence of abnormal fetal outcome.

In a further attempt to delineate pre-clinical diabetes, Fajans and Conn[2] reported on the use of a hydrocortisone provocative glucose tolerance test. By this means, some who had normal glucose tolerance curves upon the use of a provocative dose of hydrocortisone showed an abnormal curve. Seventy-five relatives of known diabetics and 37 controls were given glucose tolerance tests with a provocative dose of 100 to 125 milligrams of cortisone in two divided doses during an eight-hour period prior to the test. Twenty-four per cent of the relatives and only one of the controls showed positive tests. It was concluded that "cortisone priming" definitely increases sensitivity of standard glucose tolerance test without detracting from its accuracy. This has been confirmed by Berger[1] and has since become a widely used laboratory procedure.

MANAGEMENT

In the present study an attempt is made by use of the hydrocortisone provocative glucose tolerance test to determine those women with pre-clinical diabetes in whom additional fetal salvage might be achieved by appropriate insulin therapy. This study has been carried out for four years from a large obstetrical practice. Patients originally selected gave a history of two or more consecutive spontaneous abortions with no viable fetuses. During the second year of the study women having experienced two consecutive spontaneous abortions following one viable pregnancy were added to the study.

All patients were tested in the non-pregnant state. One hundred milligrams of hydrocortisone were administered orally in divided doses. Sixty milligrams were taken on retir-

ing the night prior to the test and 40 on arising on the morning of the test. Fasting blood and urine specimens were collected. This was followed by ingestion of 100 Grams of dextrose in 12 ounces of diluent. Blood and urine specimens were obtained ½, 1, 2, and 3 hours following ingestion of the dextrose. The Folin Wu method of determining blood sugars was used throughout. The glucose tolerance test is considered abnormal when two or more blood sugar readings equal or exceed the following: fasting 100 milligrams per milliliter; 1 hour after 100 Grams glucose 170 milligrams per milliliter; 2 hours after 100 Grams glucose 120 milligrams per milliliter; 3 hours after 100 Grams glucose 110 milligrams per milliliter.[4] The tested patients were divided into two groups. Those with an *abnormal* provocative glucose tolerance test were placed in Group A. Those with a *normal* provocative glucose tolerance test curve were placed in Group B. Patients were instructed to report as soon as the first indication of pregnancy appeared. At that time a detailed history was obtained and a physical examination was performed. A biologic test for pregnancy was done promptly.

If pregnancy was diagnosed the patient was immediately placed on insulin therapy using an arbitrary dosage of one-tenth of a unit of lente insulin per kilogram of body weight daily. This therapy was carried out throughout pregnancy. The dosage was selected because it is one used in insulin tolerance tests and it gives reasonable assurance that one would not get a hypoglycemia reaction.

My choice of insulin is based on the work of Fajans and Conn.[2] It is conceivable that other forms of therapy such as oral anti-diabetic drugs could have produced similar results.

All the patients in Group A were treated with insulin. Ten of the 15 cases in Group B who became pregnant were treated with a similar dosage of insulin as negative controls.

The only other therapy administered to these patients was polyvitamins, calcium and iron. Anti-emetic therapy was used in 12 patients for periods ranging from three weeks to eight weeks.

The age of the patients ranged between 22 and 36.

RESULTS

All of the Group A cases continued successfully to term. This group consisted of 65 patients, 42 of whom became pregnant and were placed on insulin therapy. Of the 42 who were pregnant 33 have completed pregnancy successfully and one was delivered at term of a stillbirth with multiple congenital abnormalities. The remaining eight cases are presently maintaining pregnancy but are not as yet at term. It should be noted that in this group there are four patients who have successfully completed one pregnancy. Two of the undelivered group had also completed successful pregnancies on therapy.

Ten of the 15 patients in the B Group who became pregnant were treated with a similar dosage of insulin as negative controls. Nine of these 10 control cases aborted during the first and early second trimester.

DISCUSSION

Paton [3] has found that babies born of prediabetic patients are abnormally large. However, babies born in this group showed no marked weight increase. The average birth weight was six pounds, 10 ounces. None of the babies exhibited hypoglycemia.

The incidence of minor complications of pregnancy was comparable to the usual number manifested in an obstetrical practice. There were no major maternal or fetal complications exhibited excepting the one stillbirth mentioned previously.

A history of known diabetes in the family background was elicited in two patients. Both were in grandparents.

Many of these patients had given up hope of ever being able to reproduce successfully. The manifestations of sincere gratitude were indeed inspiring and most rewarding.

SUMMARY AND CONCLUSIONS

A GROUP of patients who had experienced multiple abortions and who exhibited positive hydrocortisone provocative glucose tolerance curves have been studied throughout pregnancy under therapy with insulin. In this group almost 100 per cent fetal salvage has been achieved. A control group of multiple aborters with negative hydrocortisone glucose tolerance tests showed a 90 per cent fetal loss. Despite the relatively small number of patients in the study the results appear definite enough to warrant an attempt at this type of therapy in all multiple aborters with positive hydrocortisone glucose tolerance curves and particularly suggest that further larger studies in this field will be carried out. It may be that this will prove to be a major contribution toward combating fetal wastage.

Group A (Positive GT Curve)		Group B (Negative GT Curve)
	Glucose tolerance	
65	test results	42
42	Subsequent pregnancies	15
42	Treated with insulin	10
0	Spontaneous abortions	9
0%	Per cent abortions	90%
34	Pregnancies completed	1
8	Now pregnant	0
1	Fetal abnormalities	0

247 Claremont Avenue

I gladly acknowledge the invaluable assistance of Dr. Milton Landman and Dr. Rudolph Preisig.

BIBLIOGRAPHY

1. Berger, H.: Journal of the American Medical Association, 148:364 (1952).
2. Fajans, S. S. and Conn, J. W.: *Diabetes*, 3:296 (1954).
3. Paton, D. M.: American Journal of Obstetrics and Gynecology, 56:558 (1948).
4. Welsh, D. W.: *Diabetes*, 9:466 (1960).
5. Wilkerson, H. L.: American Journal of Public Health, 49:1032 (August 1959).

Child Protective Services in New Jersey

A landmark in the history of child welfare in New Jersey was reached on July 1, 1963, when the first statewide program of child protective services was inaugurated under public auspices. On that same date the former State Board of Child Welfare* assumed its new name, The Bureau of Children's Services.

The law now enables the agency to investigate oral, as well as written, complaints. If a family refuses or impedes an investigation or refuses service when help is needed by a child, the Bureau of Children's Services can seek a court order authorizing the agency to continue despite the family's opposition.

The Bureau of Children's Services offers protective services on behalf of children who are neglected, abused, abandoned, exploited or cruelly treated. The core of the program (which is geared to keeping the child in his own home if possible) is casework service to the parents. No police power is granted to the Bureau in this program. The agency cannot remove children summarily without the consent of the parents or persons having custody. This can be done only by legal process.

Complaints by letter or telephone can be made to the Bureau of Children's Services district offices. Agency offices are open Monday through Friday during the hours of 9 to 5.

G. Thomas Riti, Executive Director of the State Bureau of Children's Services, explains that the success of the agency's efforts does not rest entirely on the Bureau. "We must depend on the good faith of other agencies," continued Mr. Riti, "to do their share on behalf of children to the extent that it is consistent with their function."

Additional information about this program can be obtained from the Bureau of Children's Services at 163 West Hanover Street, Trenton 25.

*Before that it was the State Board of Children's Guardians.

Jonathan C. Gibbs, Jr., M.D.

R. V. Grieco, M.D.

James E. McKeown, B.A.

Jersey City

Hyperthyroidism Treated with Radioactive Iodine*

Results of treating more than 100 goiters with I^{131} *are summarized in this thoroughly up-to-date paper from the Jersey City Medical Center.*

Radioactive Iodine (131) for the treatment of hyperthyroidism was first introduced in 1941 and has since become well established modality. It has been used with considerable success by numerous investigators.[1 to 5]

This report gives the results obtained in the first 104 ward and private cases treated by the Jersey City Medical Center Radioisotope Department. These cases fall within the general group of patients treated for hyperthyroidism with the standard indications.

No cardiacs, juveniles, women under 35 nor possibly pregnant women were treated. Several were treated because of a recurrence after surgery or because of failure of standard medical treatment with anti-thyroid compounds.

The diagnosis was well established in each case by one or more RAI (131) uptakes, basal metabolism test, serum protein-bound iodine determination, Radioactive Iodine (131) conversion ratio and clinical findings. Most patients showed tachycardia, tremor, "nervousness," moist palms, diarrhea, leg cramps and exophthalmos.

The RAI uptake was used by us as a major guide. Our normal range for a test being 15 to 45 per cent. All patients had uptakes of from 50 to 99 per cent and high uptake normals were eliminated by using the T-3 Suppression test of Werner[6] as a medium of exclusion.

When a patient is under therapy, we feel that the clinical findings are more important than the laboratory findings in determining if additional dosages are necessary.

Patients react differently in their response to radioactive iodine. This question comes up because they may have an elevated SPBI and conversion ratio after clinical remission. These levels may remain high long after termination of therapy.

Scintiscans were taken routinely. These enabled us to determine the size and location of the gland, differentiate between diffuse (Fig. 1) and nodular goiter (Fig. 2) and produce a practical method for measuring reduction in gland size (Fig. 3) as well as outlining substernal goiters.

Initial individual therapeutic dose was between five and six millicuries both for diffuse and adenomatous toxic goiters with an average dose of 5.6 millicuries. In 58 cases of diffuse toxic goiter, the average total dose was 6.9 millicuries with a range of 2.6 to 18 millicuries. Average time required to reach a euthy-

*This work is from the Departments of Surgery and of Radioisotope Medicine, Jersey City Medical Center and from the senior author's private practice.

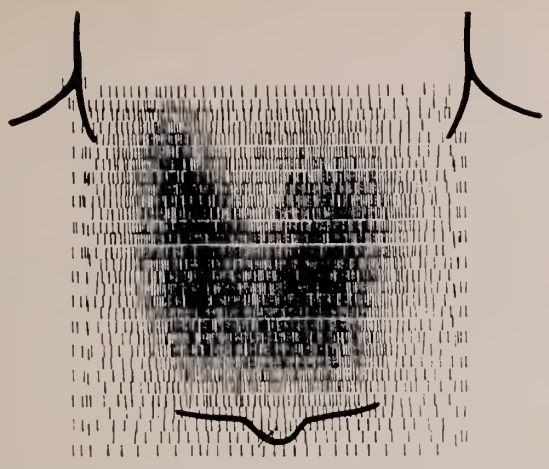


Figure 1. Scintiscan taken before therapy with RAI 131, showing diffuse enlargement of the thyroid gland. RAI uptake 89 per cent. *Diagnosis*: Toxic Goiter: Diffuse.

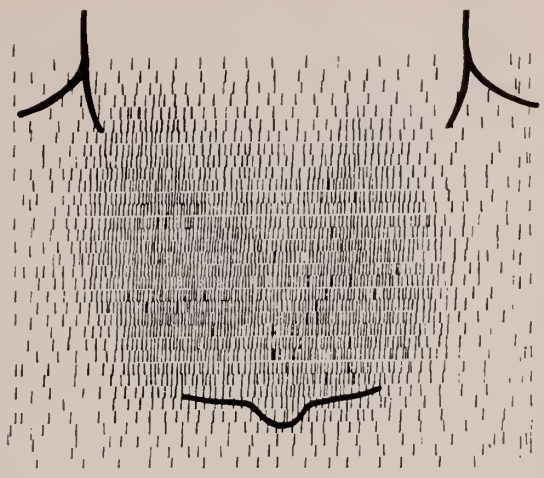


Figure 2. Scintiscan showing marked enlargement of the thyroid gland. RAI 131 uptake 57 per cent. *Diagnosis*: Toxic goiter: adenomatous (nodular).

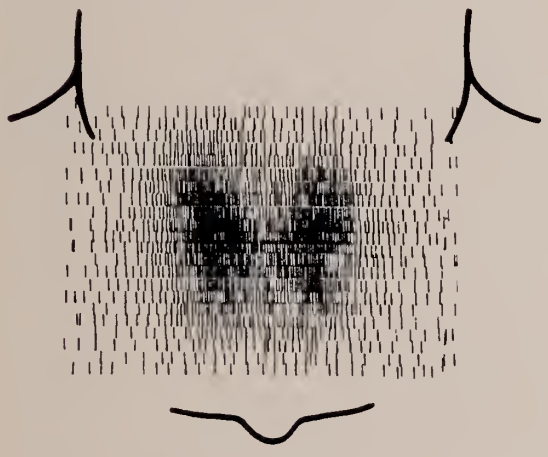


Figure 3. Scan of gland in Fig. 1 after therapy with I-131 showing reduction in size. Complete remission of symptomatology was effected.

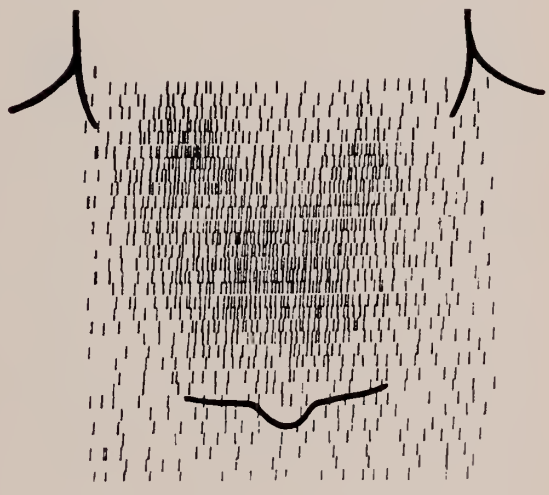


Figure 4. Scan showing segmental activity with time.

roid state was 4.7 months with a range of 2.2 months.

Additional therapy was given three months after the initial dose if the patient was not euthyroid as determined by a repeat uptake and scan, PBI and clinical re-evaluation.

Six patients became hypothyroid. The incidence of hypothyroidism is greater in diffuse goiter because too large an initial dose may be given due to the inherent difficulty in determining dosages. The generally recommended dosage being 80 uc retained per gram of gland. This group has since adopted the fractional weekly dose technic to overcome this problem with excellent results to date.[7] In 46 cases of toxic adenomatous goiter, the average total dose was 10.3 millicuries with a range of from 4 to 36 millicuries.

Average individual dose was again 5.6 millicuries. One patient was not euthyroid after 48 months with a total dose of 28 millicuries. None became hypothyroid. We find that this is a difficult state to reach in this group. And we feel that toxic adenomatous goiters are re-

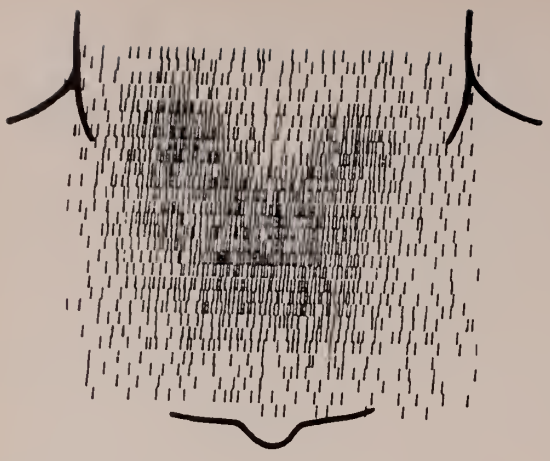


Figure 5. Same patient as Figure 4.

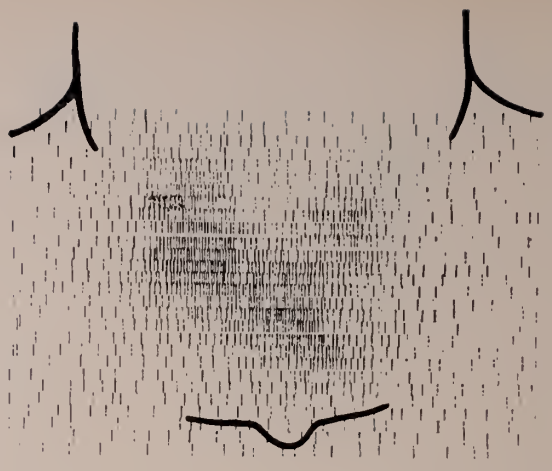


Figure 6. Scintiscan showing segmental function of an adenomatous goiter.

fractory to treatment because the uptake and distribution of radioactive iodine is not uniform throughout the gland at the time the first dose is given.

It is apparent that the adenomatous gland functions segmentally and sequentially collects iodine (Figs. 4 and 5) and the unaffected areas continue to be hyperactive. Subsequent doses suppress different areas until all of the functioning units have been uniformly irradiated.

The scan in Figure 6 shows how the different functioning areas pick up radioactive iodine in patients with toxic adenomatous goiter. This aspect of therapy is overcome by giving larger doses, the average being 50 per cent for the first dose. The most recent method of therapy which may overcome this is the fractional dose procedure. Repeated 0.5 millicuries doses are given at weekly intervals until a permanent, uniform uptake by the functioning and resting segments of the gland is obtained.

Investigators have repeatedly but futilely attempted to determine the proper dosage by actual size, weight and palpation. A standard initial dose of five millicuries is practical if large dose regimen is be followed. However, further to reduce the low incidence of hypothyroidism, the fractional 0.5 millicurie dose technic may be utilized.

The overall result in 104 cases is six per cent hypothyroid, including some lost to follow-up, who may have since become euthyroid, as Cheittin[8] indicated. Scintiscans and results of therapy are presented.

115 Gifford Avenue (Dr. Gibbs)

BIBLIOGRAPHY

1. Hertz, S. and Roberts, A.: J. Clin. Investigation, 21:624 (1942).

2. Cook, J. R., Jones, R. W. and McCullagh, E. P.: J. Clin. Endocrin. and Metabol., 15:1512 (1955).

3. Chapman, E. M. and Maloof, F.: Medicine, 34:261 (1955).

4. Werner, S. C., Coelho, B. and Quimby, E. H.: Bull. N. Y. Acad. Med., 33:783 (1957).

5. Blomfield, G. W., Jones, J. C., MacGregor, A. C., Miller, H. and Wayne, E. J.: Brit. Med. Journal, 2:373 (1951).

6. Werner, S. C. and Spooner, M.: New York Acad. Med., 31:137 (1955).

7. Ellis, F. and Oliver, R.: Clinical Radiology, 12:12 (1961).

8. Chettin, M. D., Bernstein, R. nad Langdon, E. A.: Annals of Int. Med., 31:349 (1960).

Louis Barth, M.D.

Newark

Hydrochlorothiazide for Postpartum Breast Engorgement

No miracle drug, hydrochlorothiazide has limited value in the prevention of postpartum breast engorgement.

Postpartum breast engorgement, an etiologic enigma and a therapeutic problem for centuries, was treated via a new modality, *i.e.*, hydrochlorothiazide.*

In the past, relief of the symptoms of painful postpartum breast engorgement has been attempted by using hormonal therapy, narcotics, breast binders, breast pumps, fluid restrictions, and any and all combinations of the above. To date, these have either given minimal relief or have been complicated by undesirable side effects such as rebound phenomena or uterine bleeding.

It was the purpose of this study, via the double-blind technic, to evaluate the efficacy of one of the more commonly employed diuretic agents, hydrochlorothiazide,* for postpartum breast engorgement.

Many believe that the pain and discomfort of postpartum breast engorgement is secondary to interstitial breast edema, lymphatic engorgement, or vascular engorgement and it was my theory that it may be possible to relieve this distress by increasing the physiologic diuresis usually present during the postpartum period.

For this study, 175 consecutive clinic patients were analyzed, eliminating only those that were breast feeding or required specific diuretic therapy for associated medical problems.

Each patient was assigned a separate bottle of pills. On each bottle was a code number so that this investigator had no knowledge of which patients were receiving placebo and which the diuretic. Patients varied in age from 13 to 43, and in parity from one to 13. Of the 175 deliveries, 83 were normal spontaneous deliveries, 80 were low forceps deliveries and 10 were mid forceps deliveries, while there were two cesarean sections. The obstetrical complications included two placenta previas, one abruptio placenta, five patients with toxemia of pregnancy, one CPD requiring cesarean section, six persistent posteriors and four midpelvic arrests.

All orders for breast engorgement including limitation of fluids, narcotics, and breast binders, were eliminated during this study. The orders given on each patient read simply: one tablet twice daily beginning immediately postpartum. Therapy was continued for as long as the patient was hospitalized—usually three to five days with a mean of 4.2 days.

The effectiveness of the medication was evaluated daily and summarized at the time of the patient's discharge by this investigator. This was accomplished by both questioning the patient and by daily breast examination.

Effectiveness was divided into four categories:

(A) Completely effective—No engorgement whatsoever

(B) Moderately effective—Some engorgement but no patient complaint

(C) Little effect—Those that developed engorgement with pain and tenderness, but still not sufficient to require analgesia

(D) No effect—Those with severe engorgement, with exquisite tenderness and clinically requiring either analgesia, breast binders or other forms of symptomatic therapy.

*Hydrochlorothiazide supplied by CIBA as Esidrex®.

THE DRUG

HYDROCHLOROTHIAZIDE* is a highly active derivative of chlorothiazide, qualitatively similar to the latter, but ten to 15 times as potent. Hydrochlorothiazide* markedly increases sodium and potassium excretion but has much less effect on the excretion of potassium and bicarbonate. Electrolyte imbalance should be rare. Precautions are those associated with any diuretic agent. Hypochloremic alkalosis and hypokalemia are disturbances of electrolyte balance that seldom occur. Thrombocytopenic purpura has been reported with patients taking chlorothiazide and may occur with hydrochlorothiazide.*

RESULTS

THE results of this clinical study were as follows:

(A) 34 patients received hydrochlorothiazide and 35 reeeived placebo.
(B) 15 patients received hydrochlorothiazide and 15 reeeived placebo.
(C) 25 patients received hydrochlorothizide while 38 received placebo.
(D) 1 patient reeeived hydrochlorothiazide while 12 received placebo.

Follow-up study was available on 60 of the 175 patients. Of this group only five complained of engorgement after discharge; all were symptomatic upon discharge, and all had received placebos. No side effects were noted. The patients were observed particularly for the development of signs of electrolyte imbalance, skin reactions, rebound phenomena, or any other evidence of toxic manifestations.

CONCLUSION

THE use of a diuretic agent to increase the postpartum diuresis and secondarily to prevent breast engorgement was not successful in the majority of patients. However, the regime did show merit in that only one patient in the "no effect" category (group D) had received the diuretic. It seems thus that severe breast engorgement was generally prevented when hydrochlorothiazide was given. No rebound phenomena developed on this drug, nor were there any instances of late uterine bleeding—two additional advantages.

SUMMARY

1. Hydrochlorothiazide* 50 milligrams twice a day and a placebo were given to 175 patients with the hope of preventing postpartum breast engorgement. The drug was of questionable effectiveness.

2. There appear to be no contraindications to it in the normal postpartum patient as no side effects were noted.

3. Follow-up study is indicated to establish whether the findings in the "no effect" group—category D—were significant.

ADDENDUM

To ascertain whether the findings of category D would remain consistent, 100 more patients were added. This time, all were given hydroehlorothiazide* and none were given placebo. The results followed almost exactly those noted in the double-blind study.

(A) 52 patients were free of postpartum breast engorgement.
(B) 35 patients had minimal engorgement.
(C) 11 patients were considered to have moderate diseomfort, but not sufficient to require analgesics.
(D) 2 patients definitely had severe engorgement requiring analgesia, breast binders, ice packs and other forms of supportive therapy.

When the case histories of these two patients were reviewed it was found that both had been on long term diuretic therapy, particularly in the two weeks immediately prior to term.

SECONDARY CONCLUSION

FROM the added follow-up study, it is apparent that hydrochlorothiazide* does have a prophylactic effect in the prevention of postpartum breast engorgement for patients who have not been receiving long term diuretic therapy.

306 High Street

BIBLIOGRAPHY

Edwards, L. T. and Metrezer, M. S.: J. Nat. M.A., 47:239 (1955).

Gerschieter: Diseases of the Breast. Lippineott, 138 (1945).

Gold, J. J. and Cohen, M.R.: Obst. and Gynec., 13:413 (1959).

Pichette, J. W. and Sieber, E. H.: Obst. and Gynec., 9:363 (1957).

Edward Pesin*

Newark

The Professional Service Corporation Act

Tax discrimination against private practitioners will be much reduced by those who take advantage of their rights under our new "Professional Service Corporation Act." The views here expressed are those of Mr. Pesin and have not been officially endorsed by the Medical Society.

On February 4, 1963, Governor Hughes signed into law Senate Bill No. 32, "The Professional Service Corporation Act." This is now Chapter 233 of the Laws of 1962. It permits licensed persons whose services heretofore were not permitted to be performed by a corporation to incorporate and practice their professions in corporate form. Examples of covered professions which are set forth in the Act include optometrists, chiropractors, dentists, osteopaths, physicians, surgeons, doctors of medicine, doctors of dentistry, pediatrists, chiropodists, veterinarians, and subject to the Rules of the Supreme Court, attorneys-at-law. The limitation with respect to attorneys is express recognition of the exclusive role which the Supreme Court of New Jersey has in the regulation of the practice of law in the State.

Pioneers in the area of the professional corporation or association have been members of the medical profession. Rather than sit idly by and pay the discriminatory taxes which resulted from their not being permitted to incorporate, physicians have chosen to form associations with the characteristics of corporations in the hope that they would eventually be held to be taxable as corporations under the Internal Revenue Code. This imaginative device permitted tax savings to members of such associations through employee fringe benefit plans, including the pension plan. After the Supreme Court's decision in *Morrissey v. Commissioner*[1] in which it held a certain trust taxable as a corporation on the ground that its major characteristics were corporate,[2] three doctors in Illinois organized a trust with similar characteristics to operate clinics. In holding such trust taxable as a corporation the Court relied on the Morrissey case.[3] This marked the early beginning of the professional association, or corporation. This was further advanced in 1948 when Dr. Kintner and several of his colleagues who had been practicing in partnership form organized a medical association, with corporate characteristics, in which each was a member. The association established a pension plan under which contributions were made for members by the association. When the Commissioner taxed Dr. Kintner on the amount of the association's contribution to the plan for him, he sued for refund. Relying upon the *Morrissey*[1] and *Pelton*[3] cases, the Court, in 1954, held for Dr. Kintner on the ground that the association was taxable as a corporation, and the pension plan was exempt from taxation.[4]

In both the *Pelton*[3] and *Kintner*[4] cases doc-

*Chairman of the Committee on Federal Taxation, New Jersey Bar Association.

1. 296 U. S. 344 (1935).
2. The Court found such characteristics to be: 1. association for the purpose of conducting a business and sharing its gains; 2. centralization of management; 3. continuity of enterprise; 4. limitation of personal liability to the property of the enterprise; 5. free transferability of interests.
3. *Pelton v. Commissioner*, 82 F 2d 473 (CA 7, 1936).
4. *United States v. Kintner*, 216 F 2d 418 (CA 9, 1954).

tors were *prohibited from incorporating* under State laws. The formation of entities, other than corporations, with corporate characteristics was the doctors' only recourse short of accepting their high-tax fate. At first the Government refused to follow the *Kintner* case,[4] which by now was attracting wide attention among professional persons. Finally, in 1960, it gave in to the great demand for acquiescence and clarification of its position, and promulgated its regulations on the subject, which are popularly known as the "Kintner Regulations."[5] Basically, the regulations require the same corporate characteristics in such entity as did the Supreme Court in the *Morrissey* case[1] twenty-five years earlier.

Now that more or less definite guidelines had been set out by the Government with respect to its position on such entities, many state legislatures began to provide for citizens in various professions the means to accomplish corporate tax-treatment under the Kintner Regulations.[5] Some states permitted associations with corporate characteristics. Others, like New Jersey, permitted professional persons to incorporate. All of the acts tried to include the corporate characteristics required by the Kintner Regulations, while at the same time preserving the professional relationship. To date, over thirty states have enacted such laws in one form or another and bills on the subject are pending in the Legislatures of an additional ten states.

THE ACT

BRIEFLY, the New Jersey Professional Service Corporation Act permits incorporation by one or more individuals and the conduct of medical practice in corporate form. The previously-existing professional relationship is expressly preserved, and all officers, shareholders, agents or employees of such corporation "remain personally and fully liable for any negligent or wrongful acts or misconduct committed" by them. Only practitioners licensed in the particular field may be stockholders in such corporation. This guarantees that management of the corporation will be in the hands of licensed practitioners. Under the General Corporation Law of New Jersey only stockholders may be directors.

Stock may not be sold or transferred to a practitioner outside the corporation without the consent of a majority of the other stockholders. Upon the death of a stockholder his shares must be transferred within 375 days to the corporation or persons qualified to own such shares. The corporation will have perpetual existence. If there no longer are licensed practitioners in the corporation because of death or disqualification, it will be treated as if converted into a business corporation. The corporate name must contain the last names of some or all of the shareholders and also the words "chartered," "professional association," or the abbreviation "P.A." Except where in conflict with the provisions of the Act, the General Corporation Law of New Jersey shall be applicable to a professional corporation.

FEDERAL TAX RECOGNITION

INTERNAL Revenue Service has not yet ruled on the taxability of entities created under these laws. Analysis of the New Jersey Act in the light of the Kintner Regulations[5] (which undoubtedly would form the basis of any such ruling) is encouraging in this respect. Generally, an entity organized under the Act would seem to possess all of the required corporate characteristics, except free transferability of interests because of the requirement (where stock is sold or transferred) of the consent of a majority of the other stockholders. However, since such entity would possess more corporate than non-corporate characteristics, under the Regulations, it would qualify for corporate tax treatment.

Fear of an adverse ruling by the Service should not deter incorporation under the Act in appropriate cases. Under these circumstances, the Courts which have inclined favorably toward such entities will, as usual, have the final say. From an ethical standpoint, the American Medical Association has approved the prac-

5. Reg. 301.7701-1 & 2.

tice of medicine in corporate form as long as ownership and management remain in the the hands of licensed physicians.

FEDERAL TAX ADVANTAGES

Obviously, the States would not have gone to as much trouble as they did to provide their citizens in the professions with the professional association or corporation unless there were substantial federal tax advantages to be gained. Such advantages are familiar to federal tax advisors of corporations, and include pension, profit-sharing and group life insurance plans, health and accident insurance plans, split-dollar life insurance, employee death benefits, sick pay exclusion for employees, the 85 per cent dividends-received credit on stock of a domestic corporation, and the insulation of undistributed firm profits from taxation to the individual stockholders. In addition, doctors of medicine may bring themselves under Social Security by incorporating. The pitfalls inherent in the corporate form, with proper tax planning, generally are surmountable. And, the use of Subchapter S of the Internal Revenue Code where (by a timely election by the stockholders) taxes at the corporate level, including all corporate penalty taxes, can be eliminated, should not be overlooked.

CONCLUSION

For the first time since federal taxes became a burden to the professional man, he has been furnished with a vehicle of relief—not by Congress—which has the primary responsibility in this area, but by the states, which have sought by indirect means to remedy Congressional inaction. Failure of the Internal Revenue Service to rule in this field should not deter incorporation where warranted. The six per cent interest which would be payable on any deficiency in the event of an ultimately adverse decision by the Courts might well be worth the relatively slight risk involved. Doctors can take justifiable pride in their use of a tax shelter which the pioneering efforts of their colleagues throughout the country helped to construct.

17 Academy Street

Relative Value Scales for Radiology

The American College of Radiology has announced a new Relative Value Scale for radiologic diagnostic and therapy services.

The scale was revised and approved by the College for radiologists dealing with national insurance programs. Dr. Alan Sampson, chairman of the ACR Committee on Medical Care Plans, was the principal architect of the revised scale.

"A comprehensive listing of x-ray services will be useful both as standard terminology and also to provide a reference for the comparative difficulty and expense of various procedures," Dr. Sampson said. "The College scale is not meant to replace other scales, but will hopefully provide a common section for radiology for use by any other group."

The scale lists basic diagnostic procedures by anatomic portion and then adds a special studies section for more general or complex studies. The radiotherapy section includes therapeutic isotopes. A final section lists a scale for diagnostic radioisotope procedures.

The value of the units is left to the individual radiologist and is not related to unit values in any other field of medical practice. The values cover charges for professional and for physical and technical aspects of the services rendered and for the expense of the facilities and materials used.

Copies of the scale are available upon request. Write to American College of Radiology at 20 North Wacker Drive, Chicago 6, Illinois.

Trustees' Minutes

MAY 10, 1963

The final meeting for the fiscal year 1962-63 of the Board of Trustees was held on Friday, May 10, 1963, at Haddon Hall in Atlantic City. Detailed minutes have been sent to the secretary of each component society for the full information of the membership. Below is a summary of significant actions of that meeting:

MSP Board of Trustees . . . Urged that replacement for two member-physicians who have resigned be laymen representing the subscribers rather than laymen-representatives of other socio-economic groups.

AMA-ERF Contribution to Seton Hall . . . Transmitted a check in the amount of $6,530.32, received from AMA-ERF, to the Seton Hall College of Medicine.

JOURNAL *Advertising* . . . Engaged the services of Joseph W. Cookson of Trenton as local advertising representative for THE JOURNAL, for a three-year term.

AMA Legislative Conference . . . Referred to the Council on Legislation a detailed report from Dr. A. Guy Campo, who attended the AMA Conference as the Society's official representative.

International Meeting on Electromyography . . . Endorsed the nomination of Dr. Earl F. Hoerner of Livingston as the official AMA representative to this meeting, held in Copenhagen, on June 21-23.

Cancer Society List of Physicians . . . Agreed to co-sponsor with the New Jersey Division of the American Cancer Society a revised compilation of those New Jersey Physicians willing to conduct health maintenance examinations in their private practice for detection of cancer.

MAY 15, 1963

The reorganization meeting for the year 1963-64 of the Board of Trustees was held on May 15, 1963, in Atlantic City. The significant actions of that meeting were:

Board Officers . . . Re-elected Dr. Samuel J. Lloyd of Trenton as Chairman and Dr. Nicholas A. Bertha of Wharton as Secretary.

Finance and Budget Committee . . . Re-elected Doctor Lloyd as the trustee-member of the committee for a term of three years, 1963-66.

1963 AMA Meeting . . . Authorized the following to attend the 1963 AMA meeting in Atlantic City, with expenses paid: the President, the President-Elect, the Executive Director, and two alternate delegates—Dr. F. Clyde Bowers of Mendham and Dr. Joseph R. Jehl of Clifton, Second Vice-President.

Salaried Personnel . . . Reappointed for 1963-64 at the salaries set forth in the adopted budget all salaried personnel, except those under contract.

Resignation of Office Manager . . . Accepted with regret the resignation of John P. Hartzell, effective June 1, 1963, and authorized the Special Committee on House Maintenance, Staff Policies, and Personnel Relations to fill the vacancy.

SMJAB Conference . . . Authorized the Assistant Editor to attend the Journal Conference in Chicago on October 21-22, with expenses to be borne by the State Medical Journal Advertising Bureau.

AMA Conference on Physicians and Schools . . . Designated Dr. Robert E. Jennings of South Orange as official representative to the AMA Conference in Chicago on October 10-12.

California Converted M.D. Degree . . . Agreed that, in view of the action of the House of Delegates concerning the acceptance of this converted M.D. degree, the Committee on Credentials should notify the appropriate component societies that the applicants are ineligible for membership, in accordance with this action of the House.

Nursing Education . . . Referred to the President this action of the House:

That a permanent committee on nursing education and recruitment be established—in accordance with the suggestion contained in the report, consisting of representatives from The Medical Society of New Jersey, New Jersey State Nurses' Association, New Jersey League for Nursing, administrators of nursing schools, and possibly advisers from the New Jersey State Department of Education.

Statewide Medical Examiners System . . . Referred to the Council on Legislation this resolution and action of the House:

That a change be made from the present County Coroners' System to that of a unified, efficient, and complete Statewide System of Medical Examiners.

AMA Intern Approval Program . . . In accordance with the action of the House, adopted the following revised resolution, which was sent to the AMA and to the AMA delegates of the other 49 state medical societies:

Whereas, by its adoption of Supplementary Report D of the Council on Medical Education and Hospitals, the House of Delegates—meeting in Los Angeles in November, 1962—approved a proposal threatening disaccreditation of the internship program of any hospital that failed, for two successive years, to achieve less than 25 per cent enrollment of graduates of accredited American and Canadian medical schools as members of its house staff; and

Whereas, the number of graduates of accredited American and Canadian medical schools is insufficient to fill approved internships and, as a result of the matching plan, few such graduates apply to voluntary hospitals for internships, thus making this new requirement impossible for many small but excellent voluntary hospitals to meet; and

Whereas, previously the standards for granting approval to a house staff training program had been exclusively concerned with the educational qualifications of the candidates and with the educational quality of the training program offered; and

Whereas, previously candidates qualified themselves as acceptable either as graduates of an approved American or Canadian medical school or as graduates of a foreign medical school who have successfully passed the examination given by the Educational Council for Foreign Medical Graduates; and

Whereas, by its action the House added a new standard for determining the acceptability of a candidate for admission to an approved program, a standard utterly unrelated to his educational competence—namely, consideration of the geographical area in which the candidate pursued the studies leading to his M.D. degree; and

Whereas, by its action the House would deny to graduates of foreign medical schools who fully satisfy all proper educational requirements the opportunity to serve as interns in any hospital already having 75 per cent of qualified graduates of foreign schools on its house staff roster by threatening to disaccredit such hospital if it grants further acceptances; and

Whereas, such denial of the candidate's right to a place on the house staff merely because of his geographic background would be indefensibly discriminatory, and would contravene the obligation of the medical profession of the United States—as the Council on Medical Education and Hospitals in its report so eloquently points out—". . . to play a key role in furthering one of the objectives of the Exchange-Visitor Program . . . to increase mutual understanding between the people of the United States and the people of other countries"; and

Whereas, such denial would therefore manifestly do a deep disservice to voluntary hospitals everywhere, to the fair name of American Medicine, and to our country's international relations; now therefore be it

Resolved, that the House of Delegates of the American Medical Association rescind its action taken in Los Angeles and re-establish educational and qualitative standards as the exclusive criteria governing the operation of, and admission to, approved intern and resident training programs in all hospitals, affiliated or non-affiliated, in the United States.

Utilization of Hospital Beds . . . Referred to the Council on Medical Services for study and report the recommendation of the House for "continuing study and investigation of the utilization of hospital beds."

Accreditation of Hospitals . . . Referred to the Council on Medical Services for investigation and report the resolution and House action on this subject:

The House referred the resolution (#8) on this subject to the Board of Trustees for verification of the facts the resolution presents, as well as to determine what reasons the AMA may have had for withdrawing its support. The reference committee reported these facts could not be obtained at its hearing.

Reporting of Epilepsy by Physicians . . . Referred to the Council on Legislation for implementation the resolution and House action on the reporting of epilepsy by physicians:

The resolution (#9) on this subject, approved by the House, resolved that MSNJ "oppose, condemn, and urge the repeal of the New Jersey Law, R.S. 26-5-1, requiring the reporting of epilepsy by physicians; and that MSNJ inform the New Jersey State Legislature to this effect."

Reporting of Communicable Diseases . . . Referred to the Council on Public Health the resolution and House action, as follows:

Resolution #12 on this subject was amended by the reference committee and adopted as amended by the House. It resolved that MSNJ recommend that the three categories of disease, namely epilepsy, cerebral palsy, and mental deficiency, be stricken as reportable diseases; and that the other reportable diseases listed be scrutinized with a view to bring the list of reportable diseases in line with modern medical knowledge.

Tuberculosis Control . . . Referred to the Council on Public Health the resolution and House action, as follows:

The House adopted the resolution (#13) on Tuberculosis Control which resolved that MSNJ study the current situation in the attack on tuberculosis, and in particular the recommendation of the Amberson Committee, and the role the State should now play in the financing and coordination of local efforts against tuberculosis: and that the appropriate committee of MSNJ be directed to consider and report to the Board of Trustees on these matters by October 1, 1963.

Filters Do Help

Carcinogenic activity of cigarette smoke condensates of four standard brand and two filter-tipped brands of cigarettes was studied by painting the clipped backs of mice with the refined tar (heptane soluble fraction) from the equivalent of eight cigarettes per day. Skin tumors resulted in 41 of 76 mice painted with the tar from standard cigarettes and in 15 of the 60 mice painted with filter-tipped tar. No tumors developed among two groups of the 66 mice, 1 untreated, the other being painted with acetone or dorsal regions clipped regularly, similar to the experimental group. Crude tar yield from different standard brands varied by 20 per cent but only one-third as much crude tar was produced from filter-tipped brands by the same mechanism drawing a 35 cubic centimeter puff of air at two-second intervals.

The authors* conclude that the smoke of all six brands of cigarettes was carcinogenic and pointed out that a reduction in the total amount of smoke delivered to the target area resulted in a reduction in the incidence of tumors. They added, "A parallel reduction in dose could be accomplished by smokers through smoking fewer cigarettes."

Another study† of the efficiency of cigarette filters in selectively removing smoke constituents indicates that phenols are absorbed by commercial filters in 21 to 35 per cent greater amounts than the condensate.

Six different brands of commercial filter cigarettes (five with filters) were smoked on an Ethel Mark IV machine. Cigarettes, with filters removed, were also smoked. Particulate matter was analyzed by electrostatic precipitation. For phenol analysis, smoke was trapped in special devices. From 60 to 70 per cent reduction of phenol was observed by use of commercial filters. An experimental filter with selected filter fibers and plasticizers reduced phenols 90 per cent.

Filter efficiencies for reducing particulate matter ranged between 42 and 33 per cent. The percentage differences between particulate matter and phenol reduction is considered the "selective" reduction for phenol.

The authors point out that other studies show that the degree of nicotine retention parallels that of particulate matter. They also state that phenols do not initiate cancer on mouse skin although they are thought to affect the cilia.

*Abstracted from F. G. Bock *et al.*: Journal of the American Medical Association, 181:668 (1962).

†Journal of the National Cancer Institute, 30:67 (January 1963).

MSP Statement Regarding Supreme Court Decision

The New Jersey Supreme Court decision holding unconstitutional a section of the law which required approval of Medical-Surgical Plan Trustees by The Medical Society of New Jersey creates no problems in the Plan's operations, its President said recently.

However, he warned that elimination of required participation by 51 per cent of all eligible physicians in each county would work a hardship on Plan subscribers. The court has postponed decision on this section of the law until further arguments may be heard.

Dr. Nicholas F. Alfano, President of Medical-Surgical Plan said:

"The Supreme Court decision creates no problem in Medical-Surgical Plan operations, although we had felt the requirement that has been held unconstitutional was a healthy one. In any event, it was only a part—and a small part—of the law under which we operate. Naturally we abided by it, as we have and do by the remainder of that law.

"The requirement that trustees of Medical-Surgical Plan be approved by The Medical Society of New Jersey was stipulated by the Legislature because it recognized the great contribution made by the Society in bringing the Plan into being, and thereby making it financially possible for persons of limited circumstances to afford the best of medical care.

"Furthermore, the requirement was considered reasonable and proper, since the services covered by the Plan and the fees it pays physicians are set by its Trustees, hence the physicians who make the plan operable by rendering the services should have a right to make certain that Plan trustees are properly qualified to evaluate services and fees.

"Participating physicians are bound by an agreement with the Plan to abide by all its regulations, to perform the services covered in the contract, and to accept the compensation determined by the board. Thus the board, which is responsible to the subscriber for seeing that necessary services are covered and that fees paid for them shall be no more than is just and proper, also is responsible to the Participating Physician for seeing that fees shall be no less than fair and equitable.

"So far as the Plan is concerned, the decision will in no way alter our close relationship with The Medical Society of New Jersey and its component societies. It is the cooperation of these physicians, who provide medical and surgical care to our subscribers, that makes possible the Plan's contribution to meeting the health needs of New Jersey citizens.

"Of much greater importance to the people of New Jersey is retention of the requirement that at least 51 per cent of the eligible physicians in each county be Participating Physicians.

"This guarantees our 2.3 million subscribers a wide choice of Participating Physicians throughout the entire state. It is of vital concern to subscribers whose incomes are within the limits for service benefits. Those limits are $5,000 for a single subscriber and $7,500 combined income for a husband and wife, if both are enrolled.

"Persons in these modest financial circumstances who are cared for by Participating Physicians have their bills paid in full for medical and surgical services that are covered in the contract. To reduce the number of Participating Physicians would have only one effect—it would work a severe hardship on the lower-income subscribers, by making service benefits difficult to obtain.

"The 51 per cent requirement also insures a broad representation of the various fields of medical practice, which means that a subscriber needing the services of a physician in a specialized field will be able to obtain those services from a Participating Physician.

"Through the continued support and cooperation of the Medical Society, it is our intention, in any event, to maintain participation in the Plan by New Jersey physicians at its present high rate, which represents 80 per cent of all the eligible physicians in the state, and to bend every effort to increase this.

"The Plan and the Medical Society have seen eye to eye, over the years, on the qualifications necessary in a Plan trustee. The removal of legal requirements for Society approval of Plan trustees will not in any way change our established policy of seeking men of calibre similar to that of the able, dedicated, and public-spirited trustees who have contributed so much to maintaining the Plan's high standards of service."

Summary Statement on Medical Assistance for the Aged in New Jersey*

On July 1, 1963 each of the County Welfare Boards in New Jersey began administering a new Public Assistance Program. Medical Assistance for the Aged (MAA) is the New Jersey implementation of the Federal "Kerr-Mills" Law.

The MAA program is specifically intended to provide payments directly (vendor payment) to practitioners and suppliers of specified and authorized types of health care services, on behalf of financially needy aged persons, including persons who although otherwise self-supporting, require help in paying all or part of the cost of medical care and who might otherwise forego such services or become financially dependent in the course of obtaining them.

Scope of Services Paid by MAA:

New Jersey Statute authorizes payment only when there has been a medical determination of need for one of three PRIMARY MEDICAL SERVICES (i.e. Hospitalization, Nursing Home Care, Home Health Care).

A fully licensed physician who, so far as possible and reasonable, will be chosen by the applicant, must certify need for any of the three primary types of health care(i.e. Primary Medical Services) as follows:

1. HOSPITALIZATION—Inpatient hospital ward service only—has no durational limitation (except a limit of 42 days following a diagnosis of tuberculosis or psychosis). Medical eligibility is determined by (1) verification of patient's admission to a general hospital, or (2) a written statement from the attending physician, either on his personal letterhead or prescription blank, affirming a need for hospitalization.

2. SKILLED NURSING HOME CARE—Has no duration. Medical eligibility is determined by the County Welfare Board upon certification by the attending physician, on Form PA-4 (Certification of Need for Nursing Home Care), that the patient requires intensive and long-term nursing care and medical treatment by reason of a chronic illness or disability (other than for tuberculosis or mental illness).

3. HOME HEALTH CARE—Means any and all health care services required by reason of an illness or disability necessitating confinement at home for a prolonged period. Medical need is determined upon certification by the attending physician, on Form PA-23 (Medical Certification of Need for Home Health Care), that the patient's illness or disability is such that home confinement and treatment will be required for at least 30 days.

RELATED MEDICAL SERVICES will be authorized, when medically necessary, only if they are incident to the Primary Medical Service for which the person has been found eligible. Such services include (1) physicians' services at home or office; (2) outpatient hospital or clinic services; (3) prosthetics and appliances including eyeglasses and dentures; (4) dental services at home or office; (5) chiropody services at home or office; (6) pharmaceutical services; (7) optometric services; (8) laboratory, x-ray and other diagnostic or therapeutic services; (9) use of blood or its derivatives; (10) services of a coordinated home care program; (11) nursing services at home; (12) sickroom supplies and equipment; (13) transportation to secure essential medical treatment or service; etc.

Payments for "Related Medical Services" will be allowed only when the patient has been determined medically eligible for the Primary Medical Service of Home Health Care; or, if the patient is in a medical facility (General hospital, nursing home, public medical institution or infirmary section of a home for the aged) payments will be allowed only for those specific items of "Related Medical Services" which are not part of the constellation of services for which the institution is receiving payment on a per diem or monthly basis.

MAA Does Not Pay For:

Physicians' and other practitioners' services when rendered to eligible persons receiving inpatient hospital ward services, or outpatient hospital or clinic services, etc. (see paragraph above relative to payments for "related medical services").

How to Apply for MAA:

An application is made at the office of the County Welfare Board by the person who thinks that he is eligible or who wants to have his eligibility examined. If unable to go to the office, he or someone on his behalf should write or phone the welfare board to ask that a representative of the agency make a visit.

*Supplied by the New Jersey Division of Public Welfare.

SUMMARY OF ELIGIBILITY REQUIREMENTS, OTHER THAN MEDICAL:

	Hospitalization or Home Health Care	Nursing Home Care
Age	65 years or over	
Residence and Citizenship	Must actually be living in N. J. or temporarily absent from State with intention to return. No prescribed period of residence in N.J. nor U.S. citizenship are required.	
Other Public Assistance	Must *NOT* be receiving Old Age Assistance.	
Income Limitations		
Single	$150 monthly or less but not over $500.*	$300 monthly or less
Married	$250 monthly or less jointly but not over $600.*	$450 monthly or less, jointly
Cash Resource Limitations**		
Single	Must not exceed $900.	Cash resources not exceeding $900 and $1500 *may* be permitted for temporary period of not more than 3-6 months.
Married	Must not exceed $1500.	
Combined Real and Personal Property	Must not exceed $2500, excluding value of property occupied as home.	Up to $2500, plus property used as home, *may* be permitted for temporary period of not more than 3-6 months.
Responsible Relatives	Spouse and children are required by law to assist if able.	
Repayment	Agreement to repay, enforceable only after death of both recipient and surviving spouse, is required.	

*Portion over minimum must first be applied to cost of service.

**Includes cash, stocks, bonds, savings accounts, cash surrender value of life insurance exceeding $500, and any other liquid assets.

Determination of Eligibility:

The County Welfare Board determines eligibility after a full social investigation which will include verification of financial income and resources, and other eligibility factors including verification of medical need as certified by a fully licensed physician.

Certification of Eligibility:

A certificate is provided, usually within 30 days, to the applicant who has been found eligible for medical assistance. If the welfare board determines that an applicant is not eligible, he will be so advised with the reason(s) therefor.

Duration of Medical Assistance:

MAA may be continued so long as the person has need of a Primary Medical Service, continues to be otherwise eligible, and the attending physician verifies continuing medical need by re-certification, on the appropriate official form, at least:

Every 56 days for Hospitalization
Every 90 days for Nursing Home Care
Every 30 days for Home Health Care

Vendor Payment:

Authorized payments are made directly (vendor payment) to the provider of the service or supplies, by the County Welfare Board, except that payments for inpatient hospitalization will be processed by the Hospital Service Plan of N. J. (Blue Cross) as agent for the County Welfare Board.

Rates of Payment:

Payments for health services, other than inpatient hospitalization, are identical with those allowed in the other public assistance programs administered by the County Welfare Board (i.e. Old Age Assistance (OAA); Assistance for Dependent Children (ADC); Assistance for the Blind (BA); and Disability Assistance (DA)). Rates for hospitalization will be in accordance with the provisions of the currently effective contract with Blue Cross.

This summary statement of the MAA program is necessarily incomplete. Specific questions concerning the program should be addressed to the County Welfare Board.

Announcements • • •

Symposium on Hand Surgery

The Academy of Medicine of New Jersey is sponsoring an all-day symposium on surgery of the hand at the Essex House in Newark on Wednesday, September 25. Six separate presentations will be made. Members of the Academy, interns, and residents may attend free of charge. Registration fee for all others is $2 per person.

For further information, write to: Jerome Gelb, M.D., 31 Lincoln Park, Newark 2.

Psychiatric Problems in Medical Practice

Starting Monday, October 14, the New York Academy of Medicine will present the fifth in an annual series of courses on emotional and psychiatric problems in medical practice.

The course is open to all physicians in specialty and general practice, and will consist of basic and advanced sections and a special pediatric section, meeting at weekly intervals for 14 one and one-half hour seminars in the Academy building, 2 East 103 Street, New York 29. Registration fee is $10, with a deadline of September 27.

Registration forms and further information may be obtained from Executive Secretary for Medical Education at the Academy address.

Course in Hypnosis

A course in hypnosis is offered to physicians and dentists by the University of Pennsylvania. The Department of Psychiatry is in charge.

There will be 24 weekly afternoon sessions for a total of 96 hours, beginning October 2, 1963. This is the only course in the country which meets with recommendations made by the American Medical Association.

The course will be given at the Pennsylvania Hospital, 111 North 49th Street, Philadelphia 39. The teaching staff of eight is headed by Lauren H. Smith, M.D., Chairman of Psychiatry at the Graduate School of Medicine. For further details, write to Sydney Pulver, M.D., at 111 North 49 Street, Philadelphia 39, Pa. The staff will include Dr. Harold Rosen, head of the American Medical Association's Committee on Hypnosis.

Endocrine Assembly

The Graduate Assembly of The Endocrine Society will be held at Bard Hall, Columbia University, 50 Haven Avenue, New York 32, New York, from September 30 through October 4, 1963.

Registration fee is $100. Registration must be limited to 250. The program will be published in the May *Journal of Clinical Endocrinology*. For more details, write to Dr. Nicholas Christy at 620 West 168 Street, New York 32, N. Y.

Symposium on Nutrition

The Philadelphia County Medical Society will present a symposium on Nutrition on October 2, 1963 at the Temple University School of Dentistry.

Subjects of the session will include "Nutrition Education"; "The American Diet, Fact and Fancy"; "Diet Prescription"; "Manifestations of Nutritional and Metabolic Disturbances"; "Nutrition in Relation to Coronary Artery Disease" and "Nutritional Anemias."

The morning session will be chaired by Dr. Henry Schwarz of the Philadelphia General Hospital and the afternoon session by Dr. Michael G. Wohl of the Philadelphia County Medical Society.

Attending physicians will be credited by the American Academy of General Practice for six hours Category II.

All readers of this JOURNAL are welcome to attend. For more details, write to Dr. Michael Wohl at 1727 Pine Street, Philadelphia 3, Penna.

Symposium on Aging of the Lung

Hahnemann Medical College is sponsoring a postgraduate course on aging of the lung for the three-day period beginning November 18. Meetings will be at the Sheraton Hotel in Philadelphia. The seminar will consist of biochemistry, morphology and physiology of the lung as it relates to the aging process.

For further information write to: Executive Secretary, Postgraduate Education, Hahnemann Medical College, 230 North Broad Street, Philadelphia 2, Pennsylvania.

Hypnosis Course

Beginning October 19 and for six consecutive Saturdays, a course in hypnosis will be given at the College of Physicians and Surgeons at Columbia University. The hours are 9:00 to 5:00 and the overall fee is $125. Registration is limited to physicians.

For further information, write to: Assistant Dean, College of Physicians and Surgeons, 630 West 168th Street, New York 32, New York.

Courses for Otolaryngologists

Courses in microsurgery of the temporal bone for otosclerosis and chronic otitis media are being offered to otolaryngologists at the Temple University Medical School and Hospital. The courses include televised operative demonstrations, lectures, and cadaver dissection.

The courses are scheduled for three sessions: September 16-20, October 7-11, November 25-29.

For additional information, write to: Department of Otology, Temple University Hospital, Broad and Ontario Streets, Philadelphia 40, Pennsylvania.

Fellowship in the Medical Sciences

The Glorney-Raisbeck Fellowship in the Medical Sciences for the academic year beginning July 1, 1964 will be awarded by The New York Academy of Medicine for research and /or study in any field of medicine or allied sciences. The Fellowship is renewable on a year-to-year basis for two additional years. It carries a stipend of $6,000. This award is open to M.D.'s who have demonstrated potential for productivity in research and teaching, and who live in New York and adjacent states. New Jersey physicians are eligible.

A candidate should be prepared to give assurance that he will have an institutional appointment which will enable him to carry out the objectives of his program of research and/or study. Such institutions will be encouraged to supplement the Fellowship stipend.

Deadline for receipt of application is November 1, 1963.

Requests for forms and additional information should be addressed to the Committee on Medical Education, The New York Academy of Medicine, 2 East 103 Street, New York 29, New York.

Gastroenterology Course

A course in gastroenterology will be given at the Shoreham Hotel in Washington, D. C., October 24, 25 and 26. Moderators will be Dr. I. Snapper and Dr. Robert J. Coffey.

The faculty will be drawn from medical schools around Washington. The course will cover the diagnosis and treatment of gastrointestinal diseases including comprehensive discussions of diseases of the mouth, esophagus, stomach, pancreas, spleen, liver and gallbladder, colon and rectum. A clinical session will be held in Washington in addition to the several individual papers to be presented. For details, write to the American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

Nursing Home for Multiple Sclerosis

In our entire country, there is only one nursing home exclusively for victims of multiple sclerosis. And this installation is right here in New Jersey. Located at Chester, it provides 31 beds. If public support is sufficient, the sponsoring organization hopes to double or treble its capacity. Four of its beds are for short term use "aimed at accommodating patients to give families a brief respite." The institution charges $300 a month, and it is expected that, for many patients, contributory allowances toward this will be made by County Welfare Boards and/or the sponsoring Multiple Sclerosis Service organization. The medical director of the home is Dr. Joseph I. Cillo of Chester. The Multiple Sclerosis Service organization is headquartered at 115 Fourth Avenue in East Orange, and requests for more information may be sent to the organization's medical advisor, Dr. Allen Welkind at that address. The Multiple Sclerosis Service organization provides a wide range of services for patients with multiple sclerosis.

Catalog of Medical Films

Motion pictures are an important tool in the training of physicians, nurses, and others. There is now available an indexed catalog of medical motion films covering every aspect of medicine. This is prepared by the American Medical Association, and information on this catalog may be obtained by writing directly to the AMA.

Fellowships in Allergy

Three fellowships in allergy—each for two years—have been established under the auspices of the Allergy Foundation of America. The stipend is $5,400 for the first year and $6,300 for the second year, plus a small amount made available for travel expenses.

For application and further information write to: Allergy Foundation of America, 801 Second Avenue, New York 17, New York.

New OB-GYN Diplomates

At its meeting in May, the American Board of Obstetrics and Gynecology certified the following New Jersey practitioners:

John F. Barrett, Westwood
William F. Besser, Princeton
Mervin L. Binder, Newark
Richard A. Botta, Allendale
Reynold E. Burch, Newark
Gerard T. Cicalese, Belleville
Daniel W. Colburn, Spotswood
Bernard M. Covalesky, Dover
Michael R. DeVita, Paramus
Edward Diamond, Irvington
Crosby J. Eaton, Flemington
Robert G. Faux, Chatham
Jerrold S. Finkel, Fords
Richard P. Gotchel, Woodbury
Gifford Grimm, Neptune
Philip Grundfest, Kearny
Andre Heltai, Cliffside Park
Leonard M. Hirsch, Perth Amboy
Martin N. Malachowsky, Long Branch
Angelos L. Paraskevas, Iselin
Thomas L. Pasquale, Newark
Edwin J. Pear, Wayne
Robert G. Proctor, Princeton
Donald R. Reisfield, New Brunswick
Philip A. Rosenfeld, Perth Amboy
Morris Salzman, Hackettstown
Irving Schreiber, Dover
Martin B. Stahl, Perth Amboy
John B. Voskian, Hasbrouck Hts.
William A. West, Camden
William H. R. White, Red Bank
Arthur D. Wilson, Somerville

New American Board Pathologists

The American Board of Pathology announces that it has awarded board diplomas to the following New Jersey practitioners:

Dr. Shigeo Kondo, Orange
Dr. John C. Stirling, Hoboken
Dr. Fritz Tassy, East Orange
Dr. Eugene Tschekunow, Phillipsburg.

New State Laboratory Director

Dr. Roscoe P. Kandle, State Commissioner of Health, has announced the appointment of Martin Goldfield, M.D., to succeed Elmer L. Shaffer, Ph.D., who last month retired from his post as Director of Laboratories in the State Department of Health. Dr. Shaffer was Director of the Division for 11 years. Dr. Goldfield has been with the Department since 1958 and has been serving as Assistant Director of the Division.

Dr. Shaffer will serve as a part-time consultant to the Department and will have responsibility for developing a Blood Bank Control Program; for developing a pathology seminar to be held in December, 1963; and will provide consultant pathologist services to the Department.

Nursing Home Drug Booklet

A pioneer booklet on the preparation and development of pharmacies and nursing homes is now available. This includes the basic information needed by nursing home operators in storing, dispensing, and administering drugs; material on labelling, packaging, and procurement of supplies; and classification of drugs.

Single copies of this unique pamphlet are available without charge from the American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington 7, D. C.

Jersey Physicians Honored by ACP

Nineteen New Jersey physicians were recently honored by the American College of Physicians. Elected as Fellows were: Monroe H. Mufson of Denville; Charles D. Roberts of Englewood Cliffs; Huerta C. Neals of Jersey City; Hyman W. Fisher of Livington; Donald P. Burt of Morristown; Seymour Lifschutz of New Brunswick; William C. Giordano of Ridgefield; Charles A. Bailey of Ridgewood; Frederick B. Cohen of South Orange; Peter Kornfeld of Tenafly; John C. Wood of Trenton; and LeRoy D. Homer of Woodbridge.

Selected as Associates were: Edward A. Partenope of Colonia; Jesse D. Greenberg of Englewood; Emil Neilbart of Irvington; Calvin E. Oyer of Kearny; Seymour F. Kuvin of Morristown; Radford Brokaw of Plainfield; and Harvey Rothberg of Princeton.

Obituaries • • •

DR. MICHAEL W. AGOLIA

Dr. Michael W. Agolia of Union City, director of orthopedics at St. Mary's Hospital, Hoboken, died at that hospital on April 4, 1963. Dr. Agolia was a former president of the staff at St. Mary's. Born in New York, he received his M.D. at Georgetown in 1929. During World War II, he was a major in the medical corps at a South Pacific post. Dr. Agolia was an FACS who was a pioneer in work with crippled children and was a consultant to the Elks program in this field.

DR. JAMES GORDON BOYES

Word has come from Fort Lauderdale, Florida, of the death there, on June 8, of James Gordon Boyes, M.D., a long time resident of Union County and one of our state's pioneer radiologists. Dr. Boyes was born in Ontario, Canada, in 1894. He received his M.D. at the University of Western Ontario in 1920, interned at St. Luke's Hospital in New York City. Then in 1925 he moved to Plainfield, and served the people and hospitals in that area for 35 years. He was a board diplomate in radiology, and active in the affairs of the Union County Medical Society. He was director of x-ray or consultant in radiology at several hospitals in the Union-Somerset area.

DR. HOWARD M. COOPER

Three years ago, the boro of Rutherford proclaimed Dr. Howard Cooper its "outstanding citizen of the year." In 1963, on April 16, Dr. Cooper died in Florida. Dr. Cooper was born in 1882, and along with Dr. Charles Cropsey and Dr. William Carlos Williams, constituted Rutherford's famous medical trio. Dr. Cooper was a 1910 graduate of Hahnemann Medical College. He was always "the family doctor" and never listed himself in any way except "general practitioner." He was an assistant county medical examiner and, for two decades, his boro's senior police surgeon. At the time he received the "outstanding citizen" award, several officials made the same comment: Dr. Cooper would always come when someone needed him!

DR. SAMUEL M. DERN

Dr. Samuel M. Dern, a Middlesex County practitioner, died after a brief illness on April 14, 1963. Dr. Dern received his M.D. at Johns Hopkins in 1933 and practiced general medicine with a special interest in pediatrics. He was active in the affairs of the Middlesex County Medical Society and has had offices in Woodbridge and Metuchen.

DR. ARCHIE K. GED

A heart attack on May 17 took the life of 46-year-old Archie K. Ged, a Paterson general practitioner. Born in Paterson, Dr. Ged went to St. Peter's College in Jersey City. He then matriculated at the medical school of the American University in Beirut, Lebanon, from which he received his M.D. in 1943. He was promptly commissioned in the medical corps of the Army of the United States and served with distinction in China and Burma. He then returned to his native city and became a member of the staff of St. Joseph's Hospital there. He was also active in the American Academy of General Practice.

DR. AARON H. HORLAND

Death came suddenly to Dr. Aaron Horland on April 11, 1963. Dr. Horland was a pioneer in aviation medicine and had been active in that specialty since 1935—making him probably one of the senior flight surgeons in the country. Born in Newark in 1899, he received his M.D. at Bellevue in 1926. After interning at the Beth Israel Hospital, he entered private practice. He was one of the group which founded the New Jersey Chapter of the American Academy of General Practice and was one of its first presidents. He taught general medicine at New York's Postgraduate Hospital. He was a flight surgeon during World War II and was one of the few physicians who ever personally piloted combat planes.

DR. SAMUEL E. KRAMER

Dr. Samuel Emanuel Kramer, director of Urology at Perth Amboy Hospital, died at his home in Metuchen on June 2, 1963. Dr. Kramer was born in 1900 and received his M.D. at Northwestern in 1924. He soon specialized in urology and became a board diplomate in that specialty. He was clinical professor of urology at New York Polyclinic. Dr. Kramer served the Middlesex County Medical Society on numerous committees. He conducted a number of research projects in his chosen field and authored some 20 papers on various aspects of urology.

DR. ALOYSIUS PADDEN

At the untimely age of 55, death came suddenly to Aloysius Padden, M.D. of Oradell. Dr. Padden was originally a pharmacist, being graduated in 1926 at the Fordham University College of Pharmacy. Then, in 1932 he entered medical school at Bellevue and won his M.D. in 1936. After interning at the Hackensack Hospital, he practiced briefly there but immediately after Pearl Harbor—in December 1941—he was commissioned in the medical corps of the Army. He was on active duty in both the European and African theatres and was demobilized in 1946. He then became associated with several industrial plants, serving as medical director or consultant in industrial medicine. Dr. Padden died on June 11, 1963.

DR. SAMUEL SALASIN

Atlantic County lost one of its senior citizens on March 22, 1963, with the death that day of Dr. Samuel Lyon Salasin. Born in Philadelphia in 1884, he received his M.D. in 1907 at the old "Medical-Chi" in that city. After interning at Philadelphia General Hosptal, he moved to Atlantic City and, after service in the medical corps of our Army in 1917-1918, he opened an office for private practice at the shore resort. Dr. Salasin was interested in internal medicine and public health, and for 40 years was Atlantic City's Health Officer. He had a tour of duty as president of the Atlantic City Hospital, and served also as president of our Atlantic County Medical Society. He was also an FACP, and was a consultant at the County Hospital in Northfield.

DR. HENRY ROBERT SPINNLER

A heart attack on June 4, 1963 took the life of Dr. Henry R. Spinnler who, at the time of his death, was only 44 years old. A general practitioner, Dr. Spinnler was affiliated with the Franklin Hospital in Sussex and with the St. Joseph Hospital in Paterson. Born in Paterson, Dr. Spinnler received his M.D. in 1941 from the University of Maryland. He was surgeon to the fire department of West Milford and to several local American Legion posts. Dr. Spinnler was active in the Passaic County Medical Society.

DR. CHARLES I. VAN WINKLE

Death came to Dr. Charles Ingersoll Van Winkle on May 29, 1963. He was only 58 years old at the time of his premature death. Dr. Van Winkle, a Rutgers graduate, received his M.D. in 1930 at Columbia University's College of Physicians and Surgeons. He was a general practitioner with special interest in gastro-enterology. He was on the staff of the Hackensack Hospital, and was active in the affairs of the Bergen County Medical Society. He had served variously as Rutherford police surgeon and school physician. During all of World War II, he was with the Navy Medical Corps on foreign and shipboard assignments.

DR. JEFFERSON WEED

At the early age of 55, Dr. Jefferson Weed suffered a fatal coronary attack at his home. Born in New York City, he received his M.D. at Cornell in 1935. He interned at the Nassau Hospital in Mineola and then became affiliated with Bellevue Hospital until he joined the Army in 1942. He served for three years as a battalion surgeon in New Guinea. On being mustered out in 1946 he was invited to become a full-time physician with the Mutual Benefit Life Insurance. In 1956 he was named Associate Medical Director and in May 1959, he became Medical Director of the company. He served in numerous civic capacities and was a trustee of the Glen Ridge Community Chest.

DR. KENNETH W. WHEELER

At the untimely age of 61, a heart attack took the life of Dr. K. W. Wheeler, an Essex County urologist. Dr. Wheeler died on April 28, 1963. He was chief of urology at Newark Presbyterian Hospital and also at St. Michael's Hospital, as well as consultant in genito-urinary surgery at several hospitals in the northern New Jersey area.

Born in New York City, Dr. Wheeler received his baccalaureate degree at Colgate in 1922 and his M.D. at Columbia University's College of Physicians and Surgeons in 1926. He interned at the Newark City Hospital. Dr. Wheeler served a term as president of the Essex County Anatomic and Pathologic Society and was a diplomate of the American Board of Urology. During World War II, he was a commander in the medical corps of the U. S. Navy.

DR. NEIL McLEOD WHITTAKER

A graduate of Columbia University's medical school class of 1903, Neil McLeod Whittaker died on June 5, 1963 at the age of 85. He first practiced in his native Brooklyn, and was the first physician there to develop the free milk stations for indigent babies. In 1918 he moved to Hackensack and he served the people of Bergen County for 42 years—until his retirement in 1950 at the age of 78. He was an emeritus member of our Bergen County Medical Society. He was also an amateur painter in oils of considerable talent and some of his paintings won exhibit space in galleries in Florida, New York City and California.

Book Reviews

Early Detection and Diagnosis of Cancer. W. E. O'Donnell, M.D., Emerson Day, M.D. and Louis Venet, M.D. St. Louis, 1962. Mosby. Pp. 286 with 85 illustrations. ($12.00)

About half of all cancer victims, Dr. John Heller has said, could be cured if their lesions were detected as early as is now possible. With that in mind, this unique book has been written. It includes a down-to-earth chapter on the cancer detection examination and then separate sections on the various body systems—lungs, gastrointestinal, and so on, with very practical suggestions on early detection. Little space is devoted to the details of pathology. Some x-ray pictures are included, but the authors sensibly urge seeking an opinion of the radiologist rather than trying to read films on a do-it-yourself basis. The material on differential diagnosis is centered on the theme of "assume it's cancer until proved otherwise." The book gives scant space to tabulations of five-year survival rates, quoting Ogilvie's dictum that such statistics are either "too true to be good or too good to be true." All-in-all this is one of the handiest volumes we have seen, and—to quote the introducer—"physicians who use this book faithfully can hardly fail to detect cancer in the critically important early stage."

VICTOR HUBERMAN, M.D.

Suicide and Mass Suicide. Joost Meerloo, M.D. New York, 1962. Grune and Stratton, Pp. 154. ($3.75)

The power to kill oneself is the ultimate freedom. This leaves each person one weapon. He can always leave life if the going gets too tough. So it is that depressed people may exercise a kind of emotional blackmail, as their loved ones yield to them rather than face the possibility of suicide. It is a real possibility, too; 20 per cent of suicide threats are followed by serious attempts.

In this brief but compact work, Dr. Meerloo points up these and many other aspects of the problem. He believes that one suicide can start a chain of them: a rather doubtful thesis. He discusses how the urge to be a hero can lead to suicide or to death-defying antisocial action. He reviews the evidence that hopelessness (whether in a fatal illness or in a concentration camp) can drain out the will to live and so lead to psychic suicide. He discusses the way in which friend, family or physician can give the depressed patient the warmth of contact and sympathy he so desperately needs. He recognizes that there *are* people who collect injustices to themselves, and masochistically enjoy being victims.

The book makes good reading. It stimulates thought. It compels us to look steadily at a topic usually dismissed as too morbid for discussion. Man, after all, is the only animal that can contemplate its own death.

HERBERT BOEHM, M.D.

Textbook of Ophthalmology. Francis Heed Adler, M.D. Philadelphia, 1962, W. B. Saunders Co. Seventh Edition. Pp. 560. Illustrated. ($9.00)

The seventh edition of that venerable text originated by Dr. Sanford Gifford as revised by Dr. Adler, serves its purposes remarkably well. The information in the book is eminently useful. It is directed to the general practitioner and the medical student. Especially good are the sections on ocular motility, diseases of the retina and on neurologic disorders. The small section on therapy is useful, although local penicillin is, perhaps, given too much approval. A valuable and novel diagnostic index has been added to this edition. Here various symptoms, visual and non-visual, are listed and their possible bases described.

The reasons for the popularity of this well-written text are all obvious in the reading of it.

S. JEROME GREENFIELD, M.D.

Tumour Viruses of Murine Origin. Ciba Foundation Symposium. G. E. W. Wolstenholme and Maeve O'Connor. Boston, 1962, Little, Brown & Co. Pp. 441. 72 Illustrations. ($10.75)

This volume marks a compilation of the fourth series of Ciba Foundation Symposia, at which some 28 international authorities on virology and immunology were invited guests. The text is printed in an especially readable style, and in this aspect is superior to the manner in which previous symposia have been reported. Reproductions of electron microscopic photographs present to the reader a concept of virus particles. While the symposia was primarily for the discussion of viruses peculiar to mice, occasionally the material reports information from the general field of virology. At times, the simple reporting of facts pertaining to mouse virology became monotonous; however, the chapter devoted to the work of Dr. Ludwik Gross on mouse leukemia virus was a very concise and stimulating review of his original publication.

The schematic drawings representing the morphology of both the oncogenic and non-oncogenic viruses of mice presented on page 43 are commendable.

The group discussions and the discussions at the end of some of the chapters were confusing, rather

than enlightening, in that few answers to anything were provided. The group discussion on cancer causation is best summarized by quoting Dr. Kaplan's remarks: "All the work that has been done on virus carcinogenesis has not really elucidated anything about the mechanism of carcinogenesis with but one exception; namely, the virtual elimination of the lysogenic model of carcinogenesis."

As a record of the symposia, the volume is commendable. It will appeal, however, only to those who are actively interested in the field of mouse virology and perhaps to those rare mental giants who are interested in the general field of scientific investigation.

THOMAS K. RATHMELL, M.D.

Between Us Women: A Woman Doctor's Handbook on Pregnancy and Birth. Dr. Laura E. Weber. Doubleday & Co., New York, 1962. Pp. 153. ($1.95)

Here is an excellent example of what to recommend when the patient asks, "Do you know of any books I can read?" Written in an informal yet authoritative style, it starts with "Are you pregnant?" and takes the patient through the nine months of pregnancy, the preparation for delivery, the delivery, and the postpartum period. Explanations are full and simple; complications mentioned with the caution: "Don't you worry—your doctor will worry about this and know what to do."

The numerous little questions and puzzlements of the average pregnant woman are answered, and the importance of the patient-doctor relationship emphasized.

In all, an admirable little book—well worth the modest price, which obstetricians and general practitioners doing obstetrics can safely put in their patients' hands.

ZELDA I. MARKS, M.D.

The Logic of Operating Nursing. Jacqueline Willingham, R.N. New York, 1962, Springer Publishing Company. Pp. 93. Paper Back. ($1.75)

Using the title and the preface as a guide, the material covered in this book fell somewhat short of my expectations. Many areas left me with numerous unanswered questions with regard to the "logic" of the condition or situation. For example, consider the chapter on "Prevention of Infection." This was too cursory. It should have been in more detail to afford a logical approach to a very basic principle of operating room nursing. Without an explanation of the organisms and the virulence of the organisms, it is difficult for the nurse to comprehend the tremendous importance of preventing infections. This chapter could certainly have been better developed. In fact, in many areas of the book, I found details not well-explained and the information somewhat superficial.

However, on the positive side, I must praise one chapter which is well-defined and which is not stressed in other nursing books. This is the section on the need for good inter-personal relations with the operating room staff. This includes the anesthesiologist, the surgeon and each member of the O. R. team. Without such good rapport, a smooth-functioning operating room is not possible.

As the text is written now, I recommend it as a reference book for the established operating room nurse; but I question its usefulness to the technical aide because so many areas are unexplored.

FREDA VILANOVA, R.N.

The Dynasty: A Medical Novel. By Charles Knickerbocker. Garden City, N.Y., 1962. Doubleday. ($4.50)

During the past few decades, the medical profession has been the happy (for us, unhappy) hunting ground for dozens of novelists of variable attainments. From Cronin down to Slaughter nary a year goes by without some thousand pages devoted to the sex life of the intern or the midnight allarum which hurtles poor Doc Faithful from the warmth of his wife's arms right smack into the heaviest snowstorm of the year. Interspersed as a garnish are the inevitable vignettes of surgical torture so exquisite as to put our old Mandarin friends to shame.

While I have avoided most of these lucubrations like the plague and thus can claim no standing as an authority, I have a feeling that the present entry would stand a great chance for the booby prize. Written by a Maine physician who must be busier than all getout with the summer socialites, this is probably the product of those cold wintry nights when the car won't turn over and you can't wrastle up a pair for bridge. Here is no plot worthy of the name, no character except Old Parky (a nice guy, incidentally) who resembles any person living or dead, and no style which would rate more than C in sophomore English. A few bits of authentic detail which have an autobiographic ring help relieve the tedium of this sad production. I wonder which V.P. of Doubleday's summers in Bar Harbor?

MORRIS H. SAFFRON, M.D.

Rheumatic Heart Disease. By Jacques B. Wallach, M.D., Edgar F. Borgata, M.D., and Alfred A. August, M.D. Springfield, Illinois, 1962. Charles C Thomas. Pp. 174. Illustrations. ($7.50)

This book is something new in the study of rheumatic heart disease. It is a more modern report which aids in our knowledge of the subject. The authors have gone to some length in their studies of 509 autopsied cases. The book will be used as a basis of other reports in the near future. I recommend it to general practitioners, pediatricians, internists, and pathologists. It will be a useful item in any doctor's library.

WOLF LURIE, M.D.

Sustained high-level protection in peptic ulcer



SEARLE all day

SEARLE all night

with b.i.d. dosage

PRO-BANTHĪNE P.A.®

Brand of PROPANTHELINE Bromide

Prolonged-Acting Tablets—30 mg.

Pro-Banthīne P.A. provides the full anticholinergic benefit of Pro-Banthīne® plus the greater convenience and more consistent therapeutic effect of a long-acting dosage form.

Asher[1] has summarized the advantages of prolonged-action dosage forms: "First, they should be of great value in the suppression of night acid secretion in the ulcer patient. Also, in the ulcer patient, with high acid secretion during the day these drugs should be of help when used with regular doses of shorter-acting anticholinergic agents. A third application is in the chronic treatment of certain patients whose tendency to recurrent ulcer has been established."

Pro-Banthīne P.A. offers consistent, sustained anticholinergic effects for more consistent suppression of acid secretion and motility on simple twice or thrice daily dosage in most patients.

Suggested Adult Dosage:
One tablet at bedtime and one in the morning, supplemented, if necessary, by additional tablets of Pro-Banthīne P.A. or standard Pro-Banthīne to meet individual requirements.

Pro-Banthīne P.A.
is supplied as capsule-shaped, peach-colored tablets of 30 mg. each.

Contraindications:
Glaucoma; severe cardiac disease.

Possible Side Actions:
Xerostomia, mydriasis and, occasionally, hesitancy in urination. Theoretically, a curare-like action may occur.

G.D. SEARLE & CO.
CHICAGO 80, ILLINOIS
Research in the Service of Medicine

1. Asher, L. M.: The Choice of Anticholinergic Drugs in the Treotment of Functionol Digestive Diseoses, Amer. J. Dig. Dis. 4:260-275 (April) 1959.

"Doctor... I'm so tired all the time"



Lethargic patients respond to Ritalin

(methylphenidate hydrochloride)

When lethargy is a medical problem—in convalescence, chronic fatigue, mild depression, menopause, oversedation, and senility, for example—the gentle stimulant action of Ritalin (methylphenidate hydrochloride) restores normal physical and mental activity.

In his report, Siegler[1] states: "In mild depression or in clinical exhaustion syndromes, a marginal sympathomimetic drug like methylphenidate seems to be the drug of choice for initiating therapy. It does not have the toxic effects found with the amphetamines or with the hydrazines or other antidepressants."

Other significant comments on the clinical safety of Ritalin (methylphenidate hydrochloride): "At no time was there evidence of serious toxic reactions [in a study of 185 patients]. The drug did not produce alteration in blood forming factors, kidney and liver function."[2]

"No significant toxic effects have resulted after the continuous administration of methylphenidate for more than 3 years."[3]

INDICATIONS: Chronic fatigue.

CONTRAINDICATIONS: Marked anxiety, tension, and agitation.

CAUTION: Should not be used to increase mental or physical capacities beyond normal limits. Use cautiously with epinephrine or levarterenol.

SIDE EFFECTS: Nervousness, insomnia, anorexia, nausea, dizziness, palpitations, headache, drowsiness.

DOSAGE: 10 to 20 mg. b.i.d. or t.i.d.

SUPPLIED: *Tablets*, 5 mg. (pale yellow), 10 mg. (pale blue) and 20 mg. (pale orange).

REFERENCES: 1. Siegler, P. E., in Nodine, J. H., and Moyer, J. H. (Editors): *Psychosomatic Medicine*, The First Hahnemann Symposium, Lea & Febiger, Philadelphia, 1962, p. 582. 2. Lapolla, A.: Western Med. 2:383 (Sept.) 1961. 3. Yoss, R. E., and Daly, D. D.: Pediatrics 25:1025 (June) 1960.

2/3098M3

C I B A SUMMIT, N.J.

Ritalin® hydrochloride (methylphenidate hydrochloride CIBA)

Webcor Music Man

STEREOPHONIC HIGH FIDELITY TAPE RECORDER

...the ultimate in tape recorder performance!



PRICED AT only **$198.80**

- 2 and 4 track stereo operation
- 3 speeds—1⅞, 3¾, and 7½ ips.
- New, simplified "push-lever" operation
- Self-contained stereo record and playback
- Digital tape countar with pushbutton reset
- Dual voluma controls—ona for each channel
- Dual bass and trebla controls

If you're the "one in a hundred" with a highly critical ear for perfection in sound, you'll be satisfied with nothing less than the new Webcor "MUSIC MAN" stereo tape recorder. And it's ever so simple to operate! Just push the lever up to "Play"... push it down to "Stop"... move it to the left to "Rewind"... to the right for "Fast Forward." Treat yourself to a thrilling new hearing experience. Ask for a demonstration today at—

Write for catalog to Exclusive N. J. Wholesale Distributors

ALL-STATE DISTRIBUTORS

INCORPORATED

457 CHANCELLOR AVE. **NEWARK, N. J.**

WAverly 3-4900



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE MARK

The Morristown Rehabilitation Center

66 MORRIS STREET MORRISTOWN, NEW JERSEY

JEFFERSON 9-3000



NATHAN KAPLAN, M.D., Physiatrist

MARY E. JOHNSON, Chief Therapist

ANN G. McMANUS, R.N.
Director of Nursing Service

AUDREY E. TAHLMORE
Administrator

A 38-bed rehabilitation unit specializing in orthopedic and neurological disabilities. Speech therapy, Occupational therapy and psychological evaluation available.

- - - - - -

AMERICAN HOSPITAL ASSOCIATION ACCREDITATION
MEMBER NEW JERSEY LICENSED NURSING HOME ASSOCIATION



planned by professionals . . .
for professionals . . .
with dignity aand fine taste

You are invited to visit our extensive showrooms and to discuss your plan with a member of our design staff.

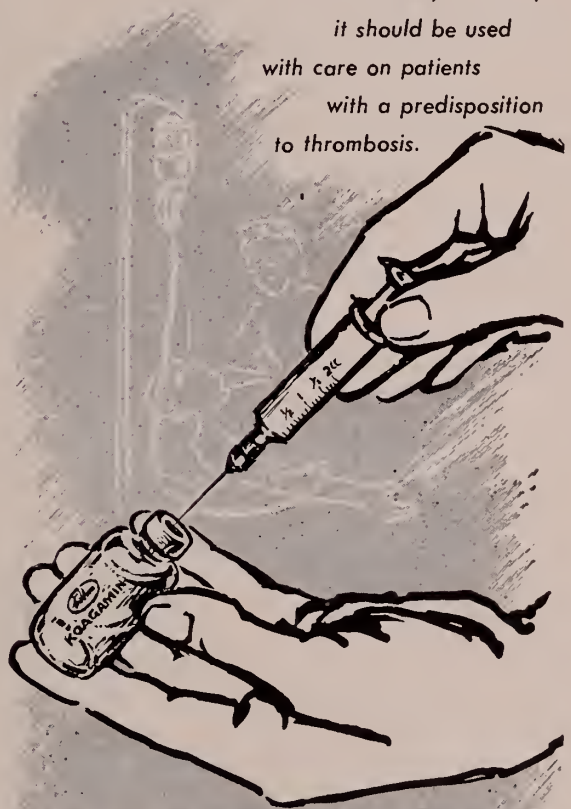
- interior designs
- space planning
- office furniture
- equipment
- accessories

the w.b. wood company

43 clinton street newark, n. j.
market 3-7900

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem. KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.



KOAGAMIN®

parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenal 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

Chatham CHATHAM PHARMACEUTICALS, INC.
Newark 2, New Jersey
Distributed in Canada by Austin Laboratories, Ltd. • Paris, Ontario

Flavoring Improves Palatability of Acidophilus Milk

In the treatment of acne vulgaris and such gastro-intestinal disorders as simple chronic constipation and simple diarrhea, patient resistance to ingestion of Acidophilus may be controlled if flavor is improved by stirring 1 to 2 teaspoons of Jell-O powder into each glass of Acidophilus Milk before serving. Most popular flavors are raspberry, cherry, orange-pineapple, blackberry, and strawberry. For patients on low-calorie diets, substitute D-Zerta for Jell-O. Add a few drops of Sweeta or Sweet-10 to the flavored Acidophilus for a sweeter drink.

WALKER-GORDON ACIDOPHILUS

2% butterfat, made from Walker-Gordon Certified Milk cultured with 300-500 million acidophilus bacilli per ml. Available through leading milk dealers.

WALKER-GORDON CERTIFIED MILK FARM, Plainsboro, N. J.

SWinburne 9-1234 (N. Y. WAlker 5-7300; Phila. PEnnypacker 5-3465)

Office Suites Available
New Medical Building

KINNELON, NEW JERSEY

Area in need of general practitioner, surgeon, obstetrician, pediatrician, dentist.

HENRY D. RICKER, Broker

BUTLER, NEW JERSEY **TE 8-0400**

THUMBSUCKING

since infancy caused this malocclusion.



THUM TRADEMARK

THUM helped break the habit and teeth returned to normal position.

THUM discourages Nail Biting too
70¢ At Your Drug Store

How Lyons Institute Serves the Medical Profession

For the past eleven years Lyons Institute of Medical, Dental and X-ray Technology has been training high school graduates to serve the medical profession as:

MEDICAL TECHNOLOGIST • MEDICAL TECHNICIAN • MEDICAL ASSISTANT
X-RAY TECHNICIAN • MEDICAL SECRETARY

Many hundreds of our graduates are employed by physicians, hospitals, clinics, laboratories, pharmaceutical concerns and private industry. If you are seeking qualified personnel in any one of the above fields, our free Placement Bureau is at your Service.

LYONS INSTITUTE of MEDICAL, DENTAL & X-RAY TECHNOLOGY

900 BROAD STREET, NEWARK 2, N. J. **Telephone: MItchell 2-3420**

Director, CRAIG R. GARTH, Captain, U.S. Navy (Ret.)
Approved by the New Jersey State Department of Education

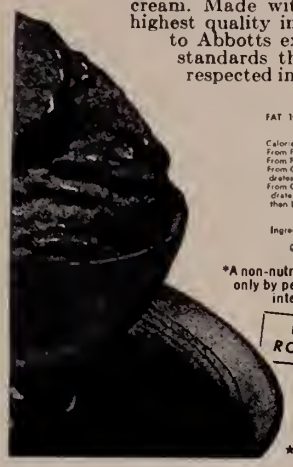
NOW! DIABETICS CAN ENJOY
(UNDER MEDICAL ADVICE)

Abbotts

ARTIFICIALLY SWEETENED

ICE CREAM

Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards—standards that are most highly respected in the dairy industry



COMPOSITION
FAT 10.52% PROTEIN 3.71%
CARBOHYDRATES 20.40%

	Per 100 Gm.	Avoir. Oz.	Fluid Oz.
Calories — From Fat	94.68	26.84	16.25
From Protein	14.84	4.21	2.55
From Carbohydrates as Lactose	20.24	5.74	3.47
From Carbohydrates other than Lactose	61.66	17.48	10.58
	191.42	54.27	32.85

Ingredients: Cream, Milk, Sorbitol, Stabilizer and 0.11% Cyclamate Calcium*

*A non-nutritive artificial sweetener for use only by persons who must restrict their inteke of ordinary sweets.

IN HANDY ROUND PINTS

At Abbotts
and Jane Logan Dealers
Abbotts Dairies

WHO PAYS THE OFFICE RENT?

And telephone bill...and utilities...and employee salaries...*if YOU are sick or injured?*

Physicians Mutual Insurance Company (The Doctors' Company) will help pay all of your usual office expenses when you are sick or disabled—if you are the fortunate owner of our new, low-rate Office Overhead Expense Policy.

Premiums are tax deductible, too!

Write today for free information . . without obligation.

PHYSICIANS MUTUAL INSURANCE COMPANY
115 South 42nd St. Omaha 31, Nebraska

PARKWAY NURSING HOME



1201 PARKWAY AVE.
Trenton, N. J.
Tel. 882-6900

No Steps!
Ranch Type
New audio-visual
call system
from every patient
to Nurses.

One of New Jersey's newest, most modern and completely equipped Nursing and Convalescent Homes, catering to the Convalescent, Aged, and Chronically Ill. Private and Semi-private rooms.

- Referring physician has full medical privileges
- Complete 24-hour general nursing care
- Physical rehabilitation department
- Beauty parlor. Air-conditioned dining room, lounge, and lobby. Spacious patios.
- Ultra modern interiors with artistic color scheme
- Stainless steel kitchen tiled to ceiling
- Special diets. Planned social and recreational activities
- Residential section

REASONABLE RATES — YOUR INSPECTION INVITED

PARKWAY NURSING HOME

NEW JERSEY STATE LICENSED — MEMBER OF AMERICAN NURSING HOME ASSOCIATION

FAIR OAKS HOSPITAL

SUMMIT, NEW JERSEY

CRestview 7-0143

OSCAR ROZETT, M.D.
Medical Director

MOLLIE KENNEDY, R.N.
Director, Nursing Service

EDWARD R. DUTY, M.D.
Clinical Director

N. M. JANI, M.D.
S. D. ESTRADA, M.D.
Associate Psychiatrists

THOMAS P. PROUT, JR.,
Administrator

AN 85 BED INTENSIVE TREATMENT PSYCHIATRIC UNIT

Certified by
The Joint Commission on Accreditation of Hospitals
The Central Inspection Board, American Psychiatric Assn.







"Prescribe with Confidence"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR
FOR MEN - WOMEN - CHILDREN



SOLD ON Rx ONLY
OUTFLAIR SHOES
FOR CLUB FEET

177A JEFFERSON AVE.
PASSAIC, N. J.

69 WESTWOOD AVE.
WESTWOOD, N. J.

350 MAIN ST.
HACKENSACK, N. J.

Dennis Brown Splints — in all sizes — carried in stock

BRUNSWICK PARK NURSING HOME

NEW JERSEY'S NEWEST, MOST MODERN HOME FOR THE CONVALESCENT, CHRONICALLY ILL AND AGED



NO STEPS

RANCH TYPE

MOST UP-TO-DATE EQUIPMENT

Reasonable Rates

Inspection Invited

- Referring physicians have full medical privileges
- Physical and recreational therapy program
- Experienced professional staff
- Special diets
- Complete 24-hour general nursing care
- Audio-Visual Nurses' call system for every bed
- Air-conditioned lobby, lounge and dining room
- Private & semi-private rooms
- Sanitary all-stainless steel kitchen, tiled to ceiling
- Tiled Wheel-in Showers and baths
- Piped-In music
- Spacious Outdoor Patios

ON U.S. 1 AT INTERSECTION N. J. 18 (Opposite Howard Johnson's)

Tel. 828-2400 Licensed by State of New Jersey **NEW BRUNSWICK, N. J.**

LONG TERM AUTO LEASING

. . A SERVICE ESPECIALLY PLANNED FOR DOCTORS!

M.D. PLATES FREE, TOO!

LONG TERM SINGLE CAR AND FLEET RENTALS

Call ORange 6-7137 or

MAIL COUPON TODAY

Lease a brand new Cadillac or other fine car from American and you'll never **buy** again. Save money, time and trouble. One modest monthly payment takes care of everything . . . insurance, maintenance, repairs, depreciation . . . and the payments are 100% tax deductible! Borrow a car—free of charge—in case of accident or breakdown.

INCLUDES

- Registration and plates
- Full maintenance
- Insurance

Liability $250/$500,000
Property damage $20,000
Deductible collision,
fire and theft

AMERICAN AUTO LEASING COMPANY
120 Halsted St., East Orange, N. J.
Please send me the AAL Long Term Leasing Plan.

Wide Selection of '63 Models

Special requirements _____

_____

Name _____

Address _____

City _____ State _____

ALL YOU BUY IS GAS AND OIL

ASK FOR BROCHURE

AMERICAN AUTO LEASING COMPANY

120 Halsted Street, East Orange, New Jersey • ORange 6-7137

POSTGRADUATE COURSE FOR PHYSICIANS

RECENT ADVANCES IN INTERNAL MEDICINE AND THERAPEUTICS

(Eighth Series)

sponsored by

The Academy of Medicine of New Jersey and the New Jersey Division and Middlesex County Chapter of the American Academy of General Practice

with the cooperation of the

Middlesex General Hospital, New Brunswick, New Jersey

Meeting Place: **Auditorium, Middlesex General Hospital, 180 Somerset Street, New Brunswick, New Jersey**

Time: **Wednesdays, 9 to 11 A.M. starting September 25, 1963**

Beginning this September, an eighth Postgraduate Course open to all physicians will be given under the sponsorship of the Academy of Medicine of New Jersey and the New Jersey Division and Middlesex County Chapter of the American Academy of General Practice with the cooperation of Middlesex General Hospital in New Brunswick. The course will make available information on recent advances in phases of medicine of greatest interest to general physicians and internists. Accreditation will be given toward meeting the requirements of the American Academy of General Practice (Category 1 credit) and of certain phases of hospital educational programs for interns and residents.

As in the previous series, the Course will be given largely by members of outstanding metropolitan medical faculties and will consist of a series of weekly two-hour sessions during a period of 34 weeks.

The 1963-64 series will cover Cardiology, Diseases of the Blood, Medical Genetics, and Gastrointestinal Disorders. Part 1 (Cardiology) will include discussions on Arterial Hypertension, Disease of the Aorta and Large Arteries, Advances in Sympathectomy, Atherosclerosis, Cyanosis, Angiocardiography, Cardiac Auscultation, Pericardial Disorders, Presymptomatic Heart Failure, Pulmonary Hypertension, Myocarditis, and Arrhythmias. Subjects to be discussed in the subsequent parts of the Course will be announced later.

The opening session is scheduled for Wednesday, September 25, 1963. IF YOU ARE INTERESTED IN ENROLLING AND HAVE NOT RECEIVED AN APPLICATION FORM, IT IS IMPORTANT THAT YOU SEND AN IMMEDIATE REPLY TO DR. S. E. MOOLTEN, MIDDLESEX GENERAL HOSPITAL, NEW BRUNSWICK, N. J. The fee for the entire course (34 sessions) is $100 (for Fellows of either Academy the fee is $90; for interns and residents $25).

CLASSIFIED ADVERTISEMENTS

Send replies to box number, c/o THE JOURNAL
P. O. Box 904, Trenton 5, New Jersey

$5 for 25 words or less; additionl words 10c each
Payable in advance of publication

Forms close 15th of the preceding month.

INTERNIST—33, board qualified, specialty training in cardiology and chest medicine. Seeks association with internist, group, or other position. New Jersey license. Write Box No. 71, c/o THE JOURNAL.

GASTRO-ENTEROLOGIST — Elizabeth, New Jersey. Fully equipped office, including x-ray, is available due to sudden death of physician practicing gastro-enterology. Sizeable referred practice can be retained for qualified gastro-enterologist.

SITUATION WANTED—Obstetrician-Gynecologist. 37, university trained, board eligible, 2 years solo practice in large eastern city. Seeks relocation in association, partnership, or group. Write Box 70, c/o THE JOURNAL.

GENERAL PRACTITIONER—For boys' residential school. Field of mental retardation. 1200 residents. All New Jersey State retirement, vacation, and sick-time benefits. 35-hour week. 30-bed hospital, excellent staff. Call Francis W. Russell, Superintendent, or James D. Nelson, M.D., Medical Director, State Colony at New Lisbon. TW 4-2211.

PRACTICE FOR SALE—Old established medical practice in excellent neighborhood. Sudden death of physician. For full details contact: Mrs. Jacob C. Fineberg, 50 Glenwood Avenue, Jersey City, New Jersey—HE 3-7589.

FOR SALE—Due to unexpected death, excellent long-established general practice available with a fully equipped, modern, air-conditioned office and residence. For further information, call HE 5-3553 or 1926 Hudson Boulevard, Jersey City, New Jersey.

FOR SALE, RUTHERFORD, NEW JERSEY—Residence and well-equipped, five-room office in center of town. Sudden death of physician in general practice for 31 years. Mrs. C. I. Van Winkle, 79 Ridge Road, Rutherford. Phone: GE 8-8889.

FOR SALE—Modern, air-conditioned, home-office for sale on Main Street, Toms River, county seat of fast-growing shore area. New hospital about to double capacity. Owner specializing in anesthesiology. Furnishings and equipment optional. Write Box No. 52, c/o THE JOURNAL.

PRACTICE FOR SALE—25-year-old practice for internist or general practitioner in Monmouth County, New Jersey; beautiful 5-year-old brick home and large 5½-room office; including 200 Ma. x-ray, all new equipment, air-conditioned. Sudden death of physician. Gross well over $50,000. Financing arranged or salary basis. H. M. Swartz, M.D., 138 Chreey Tree Farm Road, Middletown, New Jersey. OS 1-3313.

IRVINGTON—600 square foot suite remaining in new professional building, presently occupied by dentist, allergist, optometrist, and speech therapist. 1146 Stuyvesant Avenue. ES 3-1073, MU 6-0787.

FOR SALE—Home-office. Excellent northern Bergen County, New Jersey, location. Very comfortable four-bedroom house. Office area is new construction with parking facilities. DU 5-0775 or NO 4-4155.

FOR SALE—Brand-new office and dwelling combination. Roman brick ranch house 62 feet long, 6 large rooms, finished basement, ultra modern kitchen, faces one street, 40 foot office (500 square feet) faces other street on corner. Excellent location with parking, convenient to all bus facilities, near public and R.C. school, North Arlington, New Jersey. Phone WY 8-7292 or WY 8-0753.

THE FAIRWAYS—Custom-built homes, Hightstown, New Jersey, 1½ miles from New Jersey Turnpike Exit 8, U.S. Rt. 130 or N.J. Rt. 33. Peddie golf course adjacent. Homes from $25,900 and up. Beautiful residential sites. Model homes Orchard Avenue, Hightstown, New Jersey. Phone: 448-1011.

LOT FOR SALE—Hightstown, New Jersey. Ideal professional location in central Jersey's fastest growing area. Large corner lot directly adjacent to new high school and garden apartment sites. Will build to suit. Call B. Grossman, builder, owner, EL 4-7391 or 448-1011.

POSITION WANTED—Medical assistants and secretaries. Laboratory and x-ray techs. Well-trained and highly-qualified personnel (male and female) available. Phone CH 2-2330, Ext. 17, Placement Department, or write Physician Director, Eastern School for Physicians' Aides, Department 7. 85 Fifth Avenue, New York 3, New York.

Helps the epileptic to realize his potential

DILANTIN®

(DIPHENYLHYDANTOIN SODIUM)

PARKE-DAVIS



"The most effective form of emotional approach remains the demonstration to the patient that the seizure phenomena can be adequately controlled with anticonvulsant medication."[1]

At present, diphenylhydantoin sodium is generally regarded as the standard in anticonvulsant medication because of its effectiveness in controlling grand mal and psychomotor seizures.[2-10] It possesses a wide margin of safety, and incidence of side effects is minimal.[4] With this agent, oversedation is not a problem.[3] Moreover, its use is often accompanied by improvement in the patient's memory, intellectual performance, and emotional stability.[11]

Indications: Grand mal epilepsy and certain other convulsive states.

Precautions: Toxic effects are infrequent: allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Eruptions then usually subside. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Megaloblastic anemia has been reported. Nystagmus may develop. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. Periodic examination of the blood is advisable.

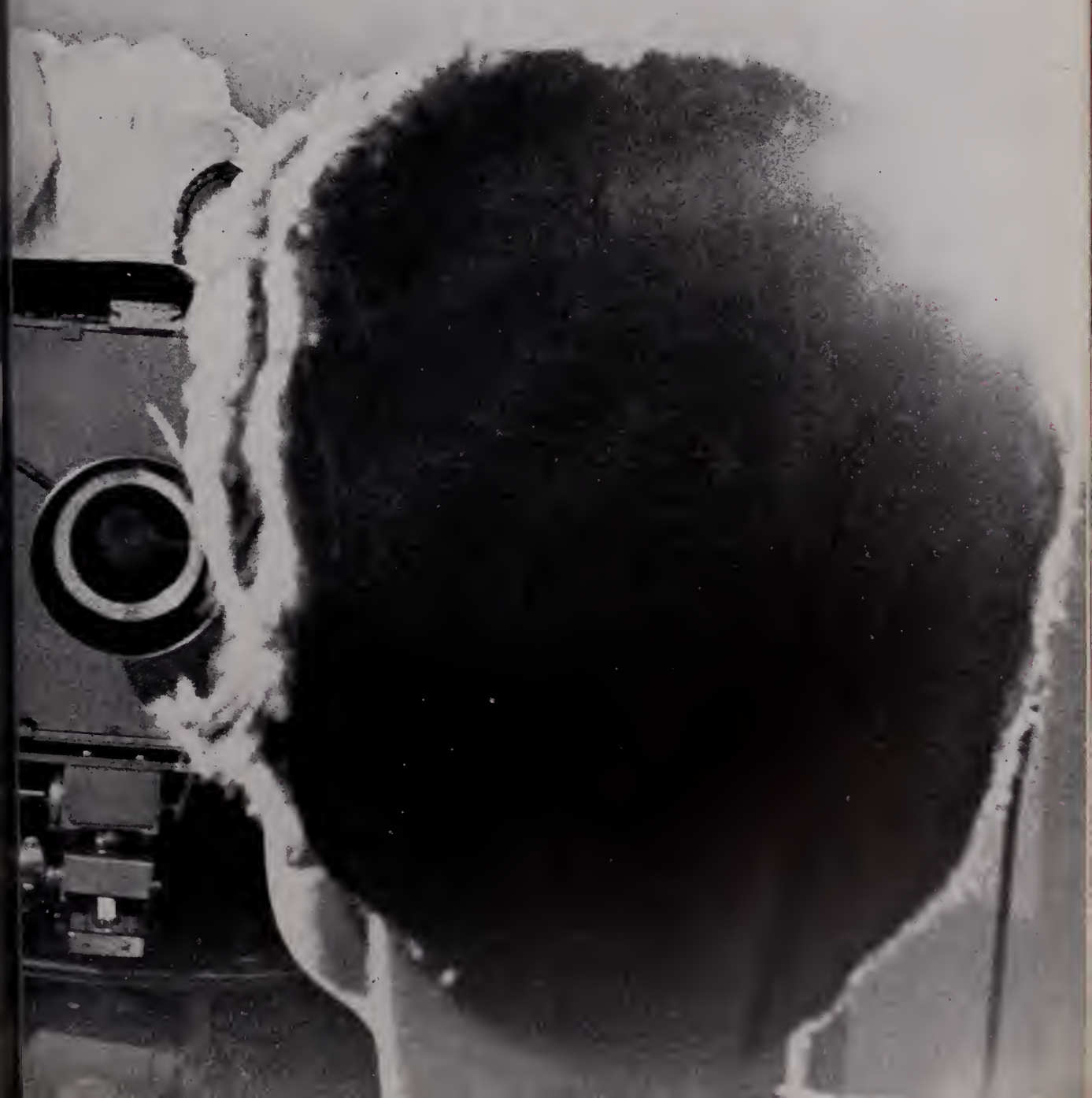
DILANTIN Sodium (diphenylhydantoin sodium) is available in several forms including Kapseals,® 0.03 Gm. and 0.1 Gm., bottles of 100 and 1,000.

REFERENCES: (1) Hammill, J. F.: J. Chron. Dis. 8:448, 1958. (2) Roseman, E.: Neurology 11:912, 1961. (3) Bray, P. F.: Pediatrics 23:151, 1959. (4) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (5) Crawley, J. W.: M. Clin. North America 42:317, 1958. (6) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (7) Ibid.: Postgrad. Med. 20:584, 1956. (8) Merritt, H. H.: Brit. M. J. 1:666, 1958. (9) Carter, C. H.: Arch. Neurol & Psychiat. 79:136, 1958. (10) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (11) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.

14863

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan



Formerly nervous and tense,
now better able to...

make decisions



This, in essence, is what happens when you place a patient on Librium (chlordiazepoxide HCl). Since this agent generally relieves anxiety and tension without dulling mental clarity or inducing drowsiness, most patients become better able to function normally, take an active interest in family and surroundings, meet and solve daily problems. This antianxiety agent is virtually free from extrapyramidal side effects, and does not produce or deepen depression.

Anxiety and tension relieved
Alertness maintained

Librium®

(chlordiazepoxide HCl) ROCHE®

the successor to the tranquilizers

ROCHE

Dosage: Usual adult dose in mild to moderate anxiety and tension is 5 or 10 mg, 3 or 4 times daily; in severe anxiety and tension, 20 or 25 mg, 3 or 4 times daily. Side effects: Drowsiness and ataxia, usually dose-related, have been reported in some patients—particularly the elderly and debilitated. Paradoxical reactions, *i.e.*, excitement, stimulation, elevation of affect and acute rage, have been reported in psychiatric patients; these reactions may be secondary to relief of anxiety and should be watched for in the early stages of therapy. Other side effects, usually dose-related, have included isolated instances of minor skin rashes, minor menstrual irregularities, nausea, constipation, increased and decreased libido. Precautions: In elderly, debilitated patients, limit dosage to smallest effective amount to preclude development of ataxia or oversedation (not more than 10 mg per day initially, to be increased gradually as needed and tolerated). Until the correct maintenance dosage is established, patients receiving this agent should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Caution patients about possible combined effects with alcohol. Caution should be exercised in administering Librium (chlordiazepoxide HCl) to addiction-prone individuals. Careful consideration should be given to the pharmacology of any agents to be employed concomitantly—particularly the MAO inhibitors and phenothiazines. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests may be advisable in protracted treatment. Caution should be exercised in prescribing any therapeutic agent to pregnant patients.

THE *Journal* OF

THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since 1904
Copyright 1963 by The Medical Society of New Jersey

Entered as second-class matter Sept. 5, 1906, at the post office, Orange, N. J., under Act of March 3, 1879
Second-Class Postage Paid at Orange, N. J.

VOL. 60, NO. 9 SEPTEMBER, 1963 50 Cents - $5.00 PER YEAR

THE A... OF MEDICINE OF NEW JERSEY LIBRARY SEP 26 1963

CONTENTS—Pages 413 to 456

EDITORIALS— Page

Research Without Animals ... 413
In the Palm of Your Hand ... 414
Chirurgeon Kai Cephalurgeon ... 414

ORIGINAL ARTICLES—

The Smoking Habits of School Children—Seymour F. Kuvin, M.D., Morristown ... 415
Ocular Pathology in Reserpine Sensitivity—Louis F. Raymond, M.D., East Orange ... 417
Retino-Cerebral Re-Education—William Rubin, M.D., New Brunswick ... 420
Atrial Septal Defect—Adrian M. Sabety, M.D.; John E. Masterson, M.D.; Hugo Gelman, M.D.; and Franklyn P. Gerard, M.D.; East Orange ... 424
Zinc Insulin Combinations—Bernard Robins, M.D., Westfield ... 428
Hearing Problems of the School Child—Henry Z. Goldstein, M.D., Newark ... 431

ORIGINAL ARTICLES— Page

Anaphylactoid Reaction to Bromsulphalein—Felix Salerno, M.D., Dallas, Texas; Joel Cherashore, M.D. and Elliott Middleton, M.D., Montclair ... 435
The Cell: Normal and Malignant—Howard B. Miller, M.D., Fairlawn ... 439

STATE ACTIVITIES—

Ob-Gyn Seminar ... 430
Trustees' Meeting: June 16, 1963 ... 447
Suggestions to Contributors ... 448
Blue Cross Excessive Hospitalization ... 450
Opportunities for Physicians in FTC ... 451
Diabetes Detection in New Jersey ... 451
County Presidents and Secretaries ... 44A

OBITUARIES ... 452
PSYCHOSOMATIC PROFILE ... 453
BOOK REVIEWS ... 454
RESPIRATORY DISEASE ABSTRACTS ... 455

Roster of Officers and Committee Listings, Advertising Pages 3A

The Medical Society of New Jersey

Endorsed Insurance Plans

ACCIDENT AND HEALTH INSURANCE

$ 1,200 a month new maximum Basic total disability benefit

ACCIDENT: from 1st day, up to 5 years (Partial Accident Disability, half benefit up to six months)
SICKNESS: from 8th day, up to 2 years

$600 a month new maximum Extended total disability benefit, continuing benefits beyond basic coverage.

ACCIDENT: extended to LIFE
SICKNESS: extended through SEVENTH year

MAJOR MEDICAL EXPENSE INSURANCE

$10,000 maximum for Covered Expenses for each accident or sickness, covering member, spouse, and eligible children. Plan pays 80% Covered Expenses after $500 deductible.

LIFE INSURANCE

$10,000 to **$50,000** of Convertible Term Life Insurance.

(Guaranteed exchangeable at any time into Permanent Cash Value life insurance without medical examination)

Applications for initial $10,000 policy and additional $10,000 policies up to $50,000 total under this plan considered during the month of November each year.

SIX POINT, HIGH LIMIT ACCIDENT INSURANCE

Up to $200,000 for member, covering accidental death, dismemberment, loss of sight, total and permanent disability, exposure and disappearance.

Up to $100,000 for spouse (without disability benefit).

Applications are subject to age limits and other company rules and regulations for acceptance of risk. New members have special privileges during the first few months of membership; ask for specific details if you were recently elected and have not received notification from us.

Information and claim service are as close as your telephone.

E. & W. BLANKSTEEN

E. & W. Blanksteen Agency, Inc.

75 MONTGOMERY STREET JERSEY CITY, NEW JERSEY 07302

DElaware 3-4340 (Area Code 201)

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATON, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.
EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154
(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

OFFICERS

President, Jerome G. Kaufman, M.D. ..... Maplewood
President-Elect, Charles H. Calvin, M.D. ..... Perth Amboy
First Vice-President, John J. Bedrick, M.D. .....Bayonne
Second Vice-President, Joseph R. Jehl, M.D. ..... Clifton
Secretary, Marcus H. Greifinger, M.D. .....Newark
Treasurer, Daniel F. Featherston, M.D. ..... Asbury Park

Richard I. Nevin, *Executive Director* ..... Trenton
Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton

TRUSTEES

Samuel J. Lloyd, M.D., *Chairman* (1966) ..... Trenton
Nicholas A. Bertha, M.D., *Secretary* (1965) ..... Wharton
Jerome G. Kaufman, M.D. ..... Maplewood
Charles H. Calvin, M.D. ..... Perth Amboy
John J. Bedrick, M.D. ..... Bayonne
Joseph R. Jehl, M.D. ..... Clifton
Marcus H. Greifinger, M.D. ..... Newark
Daniel F. Featherston, M.D. ..... Asbury Park
Louis S. Wegryn, M.D. ..... Elizabeth
Louis F. Albright, M.D. (1964) ..... Spring Lake
Louis K. Collins, M.D. (1964) ..... Glassboro
Thomas C. DeCecio, M.D. (1965) ..... Cliffside Park
Joseph P. Donnelly, M.D. (1966) ..... Jersey City
Lloyd A. Hamilton, M.D. (1965) ..... Lambertville
Frank J. Hughes, M.D. (1966) ..... Gloucester
John F. Kustrup, M.D. (1966) ..... Trenton
Emanuel M. Satulsky, M.D. (1964) ..... Elizabeth
Carl N. Ware, M.D. (1965) ..... Ocean City

COUNCILORS

First District (Essex, Morris, Union, and Warren Counties) ..... Thomas S. P. Fitch, M.D., Plainfield (1966)
Second District (Bergen, Hudson, Passaic, and Sussex Counties) ..... John L. Olpp, M.D., Englewood (1965)
Third District (Hunterdon, Mercer, Middlesex, and Somerset Counties) ..... Albert F. Moriconi, M.D., Trenton (1964)
Fourth District (Burlington, Camden, Monmouth, and Ocean Counties) ..... E. Vernon Davis, M.D., Moorestown (1966)
Fifth District (Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties) .... Isaac N. Patterson, M.D., Westville (1965)

STANDING COMMITTEES

Annual Meeting

Edward E. Seidman, M.D., *Chairman* (1964) .... Plainfield
Peter H. Marvel, M.D. (1964) ..... Northfield
Thomas M. Kain, Jr., M.D. (1965) ..... Camden
George J. Kohut, M.D. (1965) ..... Perth Amboy
Milton Ackerman, M.D. (1966) ..... Atlantic City
Herschel S. Murphy, M.D., *Vice-Chm.* (1966) ..... Roselle
Marcus H. Greifinger, M.D., Secretary, *Ex. Of.* .... Newark

*Scientific Exhibits

Milton Ackerman, M.D.,*Chairman* (1964) .....Atlantic City
Arthur Bernstein, M.D. (1964) ..... Maplewood
Louis K. Collins, M.D. (1964) ..... Glassboro
Abraham J. Gitlitz, M.D. (1964) ..... Tenafly
Thomas K. Rathmell, M.D. (1964) ..... Trenton

*Scientific Program

Herschel S. Murphy, M.D., *Chairman* (1964).....Roselle
(Chairmen and Secretaries of Scientific Sections)
*Subcommittee of Annual Meeting Committee

Credentials

Marcus H. Greifinger, M.D., *Chairman* (Secy) .... Newark
William E. Bray, M.D. (1964) ..... Pemberton
Eugene J. Tyrrell, M.D., *Vice-Chm.* (1964)....Perth Amboy
Charles P. Campbell, M.D. (1965) ..... Hackensack
Elton W. Lance, M.D. (1965) ..... Rahway
S. Thomas Camp, M.D. (1966) ..... Westville
Raymond A. McCormack, M.D. (1966) ..... Trenton

Finance and Budget

Carl N. Ware, M.D., *Chairman* (1964) ..... Ocean City
Wayne H. Stewart, M.D. (1964) ... Cape May Court House
Joseph R. Jehl, M.D. (1965) ..... Clifton
Charles A. Landshof, M.D. (1965) ..... Jersey City
Samuel J. Lloyd, M.D. (1966) ..... Trenton
Theodore K. Graham, *Vice-Chairman* (1966) ..... Paterson
Daniel F. Featherston, M.D., *Treasurer, Ex-Officio*
..... Asbury Park

Honorary Membership

F. Clyde Bowers, M.D., *Chairman* (1964) ..... Mendham
David B. Allman, M.D. (1965) ..... Atlantic City
Spencer T. Snedecor, M.D., *Vice-Chm.* (1966) .. Hackensack

Medical Defense and Insurance

Daniel F. Featherston, M.D., *Chairman* (1964)...Asbury Park
Benjamin F. Slobodien, M.D. (1964) ..... Perth Amboy
Elton W. Lance, M.D. (1965) ..... Rahway
William L. Palazzo, M.D. (1965) ..... Teaneck
Frederick A. Mettler, M.D., *Vice-Chm.* (1966)....Blairstown
Ernest C. Hillman, Jr., M.D. (1966) ..... Newark
Marcus H. Greifinger, M.D. *Secretary, Ex-Of*.....Newark

Medical Education

Sherman Garrison, M.D., *Chairman* (1965).....Bridgeton
Morris M. Saffron, M.D. (1964) ..... Passaic
Malcolm M. Dunham, M.D. (1964) ..... Woodbridge
Frank S. Forte, M.D. (1965) ..... Newark
Andrew C. Ruoff, III, M.D., *Vice-Chm.* (1966)....
..... Pompton Plains
Louis F. Albright, M.D. (1966) ..... Spring Lake
H. Irving Dunn, M.D., *Consultant* (1964) ..... Elizabeth

Medical Student Loan Fund

Luke A. Mulligan, M.D., *Chairman* (1965) ..... Leonia
Louis K. Collins, M.D., *Vice-Chm.* (1964).....Glassboro
John F. Kustrup, M.D. (1964) ..... Trenton
Frank J. Hughes, M.D. (1965) ..... Gloucester
Nicholas A. Bertha, M.D. (1966) ..... Wharton
Louis S. Wegryn, M.D., *Consultant* (1964).....Elizabeth

Publication

George B. Sharbaugh, M.D., *Chairman* (1966) .... Trenton
C. Spencer Davison, M.D. (1964) ..... Salem
James J. Fitzpatrick, M.D. (1965) ..... Princeton
Charles H. Calvin, M.D., President-Elect, *Ex-Officio*
..... Perth Amboy
Marcus H. Greifinger, M.D., Secretary, *Ex-Of*.....Newark
Henry A. Davidson, M.D., Editor, *Ex-Of.* .... Cedar Grove

Revision of Constitution and Bylaws

Louis F. Albright, M.D. *Chairman* (1965).....Spring Lake
Sherman Garrison, M.D. (1964) ..... Bridgeton
Robert E. Verdon, M.D. (1964) ..... Cliffside Park
Joseph M. Gannon, M.D., *Vice-Chm.* (1965).....Plainfield
John A. Smith, M.D. (1966) ..... South River
John J. Thompson, M.D. (1966) ..... Montclair
Marcus H. Greifinger, M.D., *Secretary, Ex-Of*.....Newark

Advisory to Woman's Auxiliary

George O. Rowohlt, M.D., *Chairman* (1966).....Dumont
Keith R. Young, M.D., *Vice-Chm.* (1964) ..... Burlington
A. Guy Campo, M.D. (1964) ..... Westville
Thomas H. McGlade, M.D. (1965) ..... Camden
Ralph K. Bush, M.D. (1965) ..... Merchantville
Volmar A. Mereschak, M.D. (1966) ..... Phillipsburg



clear the tract with Robitussin®

When summer coughs make the rounds and interfere with work and play schedules, Robitussin "clears the tract" safely. Glyceryl guaiacolate, the expectorant agent, increases respiratory tract fluid (R.T.F.) almost 200%. Increased R.T.F. helps flush mucous plugs and other irritants from the bronchi to make coughs more efficient. In the treatment of coughs in 425 infants and children, Blanchard and Ford found that Robitussin "...passed all criteria for clinical usefulness and is highly recommended."* After more than thirteen years and millions of prescriptions, no serious side effects have been reported from Robitussin. Acceptance by infants and older children has been outstanding.

*Blanchard, K., and Ford, R. A.: Clin. Med., 3:961, 1956.

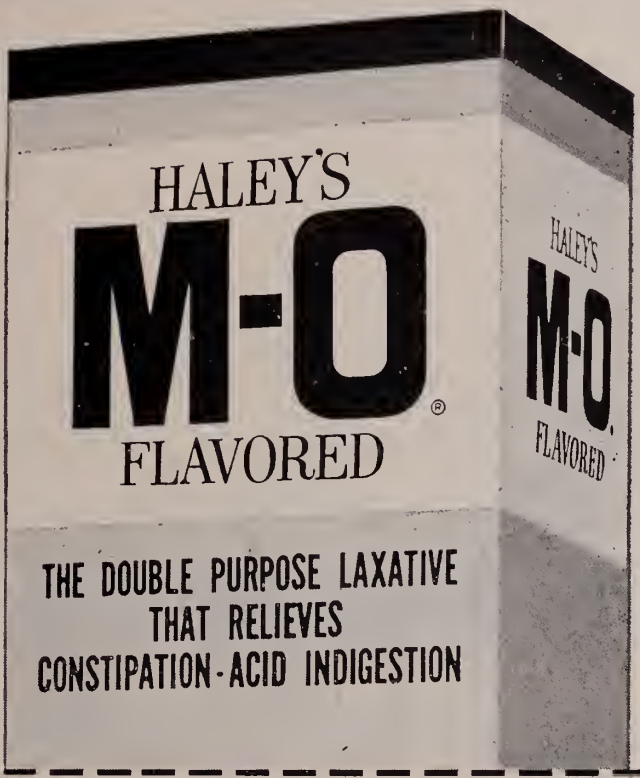
Robitussin®—each 5 cc. tsp. contains:
Glyceryl guaiacolate.....100 mg.
Alcohol 3.5%

Robitussin® A-C — Robitussin with antihistamine and codeine
Each 5 cc. tsp. contains:
Glyceryl guaiacolate.....100 mg.
Pheniramine maleate ..... 7.5 mg.
Codeine phosphate .....10.0 mg.
(exempt narcotic)
Alcohol 3.5%

PHARMACEUTICALS RESEARCH

A. H. Robins Company, Incorporated Richmond 20, Virginia

NOW ALSO IN FLAVORED FORM!



BOTTLES OF
4 OZ., 8 OZ.,
1 PT., 1 QT.

Antacid–Laxative–Lubricant to help correct constipation

Magnesium Hydroxide plus pure mineral oil make *Haley's M-O* a smooth working antacid-laxative-lubricant that efficaciously relieves constipation and attendant gastric hyperacidity.

The oil globules in *Haley's M-O* are minutely subdivided to assure uniform distribution and thorough mixture with intestinal contents. Oil leakage is thus avoided and a comfortable evacuation is effected through the stimulation of normal intestinal rhythm and blunted defecation reflex.

May we send samples for your evaluation? Just write:

THE CHAS. H. PHILLIPS CO.

Division of Sterling Drug Inc., 1450 Broadway, New York 18, N. Y.

to bring her back into balance

after menstrual irregularity



an orally active progestogen-estrogen combination

Duosterone®

Ethisterone . . . 10.00 mg. Ethinyl estradiol . . . 0.01 mg. per tablet

Supplementing and supporting ovarian function, DUOSTERONE can help release your patients from the anxiety, discomfort and inconvenience of functional amenorrhea, dysmenorrhea, and dysfunctional uterine bleeding.

Periodic progestational treatment with DUOSTERONE aims at restoring the normal hormonal pattern of the secretory phase of the menstrual cycle, providing an orally active progestogen with an estrogen to prime the endometrium for adequate progestational response.

Dosage: Functional amenorrhea, 5 tablets daily for 5 days. Dysmenorrhea, 1 to 2 tablets daily during the second half of the menstrual cycle, except for the final two days. Dysfunctional uterine bleeding, 5 to 7 tablets daily for 5 days; in mild cases, reduce dose 1 tablet each day.

Side Effects: Ethinyl estradiol may occasionally cause headache, diarrhea, engorgement and tenderness of the breasts, nausea, vomiting, cramping, or skin rash. These side effects usually fade as the patient adjusts to the estrogen.

Cautions and Contraindications: DUOSTERONE is contraindicated in carcinoma of the breast and reproductive organs and should be used with caution in cases of known liver impairment.

Supplied: Bottles of 25 and 100 tablets.

ROUSSEL

Roussel Corporation
155 East 44th Street, New York 17, N.Y.



Relieves Anxiety and Anxious Depression

The outstanding effectiveness and record of safety with which 'Miltown' (meprobamate) relieves anxiety and anxious depression has been clinically authenticated time and again during the past eight years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more than any other tranquilizer in the world.

Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

Usual dosage: 1 or 2 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50.

the original meprobamate

Miltown®

WALLACE LABORATORIES / *Cranbury, N.J.*

CM-9240



when aging brings anguish...

Leptinol

(Each bi-layer tablet contains: Pentylenetetrazol, 100 mg.; Niacin, 50 mg.; Thiamine Hydrochloride, 1 mg.; and Ascorbic Acid, 20 mg.)

Because geriatric patients compose an increasingly larger part of your medical practice, you see the problems of aging more often.

When one of your elderly patients displays the early warning signs of senile psychosis, prescribe Leptinol for safe, gentle relief from the symptoms—apathy, mental confusion, memory lapses.

Leptinol deters senile mental deterioration by stimulating the cerebral vasomotor and respiratory centers to affect a greater blood and oxygen supply to the brain and increased pulmonary ventilation.

Because no addiction or intolerance is introduced, you will also find Leptinol to be a welcome adjunct even to the treatment of slow degenerative diseases. Caution against overdosage, as Leptinol induces a sense of well-being.

DOSE: One or two tablets, three times daily. Write for descriptive literature and starter doses.

THE VALE CHEMICAL CO., INC.
Allentown, Pa.

VALE Pharmaceuticals since 1922



For comprehensive control of the whole pain complex...

Like a triad, the action of Trancogesic is direct and simple as 1,2,3. Its tranquilaxant component – chlormezanone – 1. reduces emotional reaction to pain . . . 2. decreases skeletal muscle spasm . . . and 3. its aspirin component dims the patient's perception of pain. Thus, Trancogesic controls the *whole* pain complex – *with unsurpassed tolerance.*

Each tablet of Trancogesic contains 100 mg. of chlormezanone and 300 mg. (5 grains) of aspirin. The usual adult dosage is 2 tablets of Trancogesic three or four times daily. Reactions to Trancogesic have been minor – gastric distress, and an occasional weakness, sedation or dizziness. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. Trancogesic is contrainindicated in persons known or suspected to have an idiosyncrasy to aspirin.

WINTHROP LABORATORIES, NEW YORK 18, N. Y.

TRANCOGESIC*

CHLORMEZANONE with ASPIRIN

100 MG. 300 MG.

*TRADEMARK

Winthrop

L777M

effective in sudden-onset hearing loss, tinnitus, vertigo... due to labyrinthine ischemia



arlidin®

brand of **nylidrin HCl**

"Significant hearing improvement" occurred with Arlidin (nylidrin HCl) therapy in 32 of 75 patients with recent-onset hearing impairment due to labyrinthine artery ischemia.

Rubin, W. and Anderson, J. R.: Angiology 9:256, 1958.

Vascular insufficiency of the labyrinth is an important etiologic factor in sudden perceptive deafness..."vasodilators [Arlidin] are of considerable value."

Wilmot, T. J. and Seymour, J. C.: Lancet 1:1098, 1960.

Clinical benefit was obtained in approximately 50% of cases of recent-onset hearing loss treated with adequate vasodilator and other supportive therapy.

Sheehy, J. L.: Laryngoscope 70:885, 1960.

Arlidin (nylidrin HCl) "appears to be one of the most satisfactory [vasodilators], having the advantages of minimal side effects, being well tolerated and possessing a sustained action" in improving circulation of the inner ear.

Seymour, J. C.: J. Laryngology & Otology 74:133, 1960.

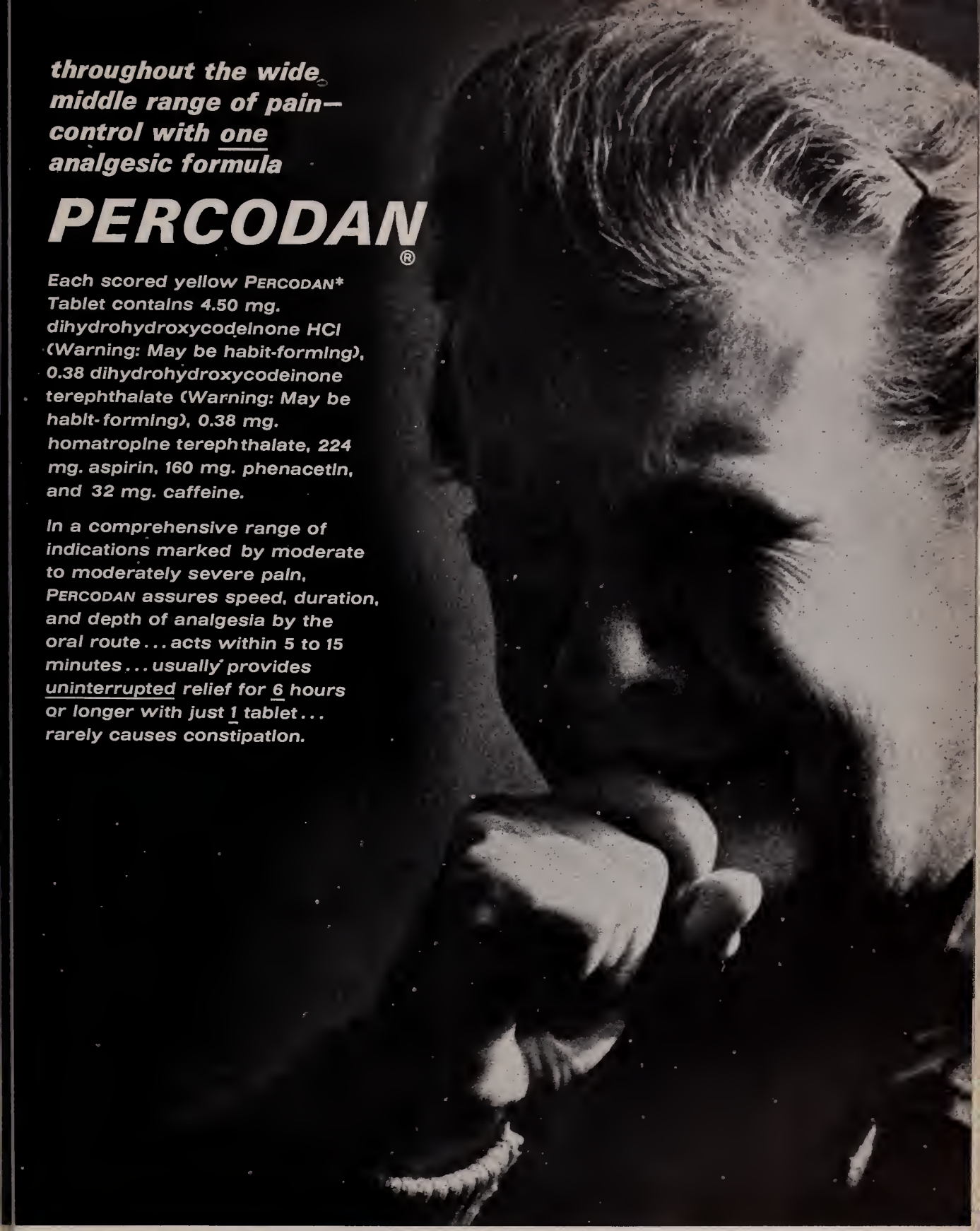
Early cases of sudden perceptive deafness should be treated by immediate stellate block "supplemented by the most effective vasodilator drug [Arlidin]... energetic measures to retain blood supply to the inner ear are imperative."

Wilmot, T. J.: J. Laryngology & Otology 73:466, 1959.

SUMMARY: Indicated whenever an increase in blood supply is desirable in circulatory insufficiencies of the extremities, brain, eye and ear. Use with caution in the presence of a recent myocardial lesion, severe angina pectoris and thyrotoxicosis. Contraindicated in acute myocardial infarction.

Arlidin (nylidrin HCl) is available in 6 mg. scored tablets, and 5 mg. per cc. parenteral solution
Protected by U.S. Patent Numbers: 2,661,372 and 2,661,373

u.s. vitamin & pharmaceutical corporation - Arlington-Funk Labs., div. • 800 Second Ave., New York, N.Y. 10017



throughout the wide middle range of pain—control with one analgesic formula

PERCODAN®

Each scored yellow PERCODAN* *Tablet contains 4.50 mg. dihydrohydroxycodeinone HCl (Warning: May be habit-forming), 0.38 dihydrohydroxycodeinone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.*

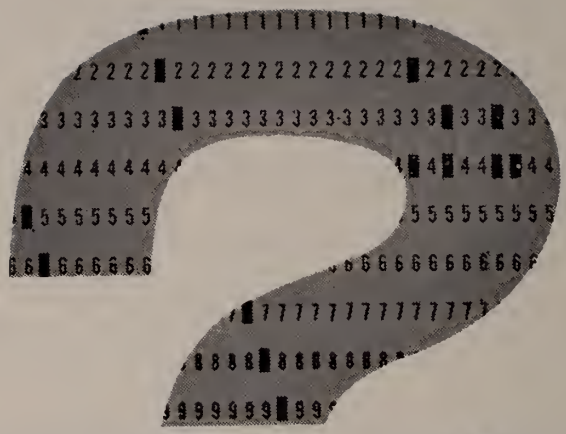
In a comprehensive range of indications marked by moderate to moderately severe pain, PERCODAN *assures speed, duration, and depth of analgesia by the oral route . . . acts within 5 to 15 minutes . . . usually provides uninterrupted relief for 6 hours or longer with just 1 tablet . . . rarely causes constipation.*

Average Adult Dose—1 tablet every 6 hours. **Side Effects and Contraindications**—Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. **Also** available: PERCODAN®-DEMI, containing the complete PERCODAN formula but with only half the amount of salts of dihydrohydroxycodeinone and homatropine. Both products are on oral Rx in all states where laws permit. Narcotic order required. **Literature on request.**

ENDO LABORATORIES Richmond Hill 18, New York

Endo®

*U. S. Pats. 2,628,185 and 2,907,768



ARE YOU CONFUSING THE COMPUTERS?



Humans can make allowances for errors committed by other humans. Machines, however, must have complete and accurate information to function properly.

Modern electronic computers are being used increasingly in processing Blue Shield Service Reports submitted by doctors. When these reports contain incorrect or incomplete information, delays in processing result, which mean delays in payments.

The computer will say "No" to a claim that lists an incorrect Subscriber's Identification Number . . . an incorrect Coverage Code Number . . . services that are ineligible under the Subscriber's coverage . . . to cite just a few.

You can help minimize delays by:

- Double-checking the subscriber's Identification Number from the patient's Blue Shield Identification Card.
- Always including the subscriber's birthdate.
- Making sure that all other necessary information is correctly entered in the Service Report.

Remember — automation requires full and accurate information for processing claims and making payments promptly. You can help us to help you.

BLUE SHIELD

MEDICAL-SURGICAL PLAN OF NEW JERSEY
500 Broad Street, Newark



The new specialist

(concentrates on coughs)

Tussicalm, by concentrating solely on cough relief, permits therapeutic and dosage flexibility in treating individual patients, since other symptoms may vary in type, frequency, onset and duration. Mixtures with multi-therapeutic effects may be unnecessary, increase danger of side effects, and result in "inadequate concentrations of effective ingredients...."[1]

With Tussicalm, patients receive concentrated 2-way action.

Noscapine—safe, effective cough suppressant.[2,3] Antitussive potency equal to codeine.[1,4-7] No addiction liability.[1,6,7] Wide margin of safety.[6-8] No opiate-like effects, such as constipation, respiratory depression or blood pressure changes.[5]

Glyceryl Guaiacolate—safe, superior expectorant. Greatly increases and thins bronchial secretions.[9] Facilitates elimination of sputum and soothes irritated bronchial mucosa.[10] Virtually no adverse effects.[9]

Tussicalm, being essentially free of side effects, is available to the whole family without prescription.

ROUSSEL CORPORATION, 155 E. 44 ST., N. Y. 17, N. Y. ROUSSEL

Each teaspoonful (5 cc.) contains in a delightfully different tasting syrup: Noscapine 10 mg., Glyceryl Guaiacolate 90 mg., Citric Acid Anhydrous 75 mg., and Sodium Benzoate 5 mg. DOSAGE: *Adults:* 2 teaspoonfuls three or four times daily. *Children* (6 to 12): 1 teaspoonful three or four times daily. *Children* (4 to 6): ½ to 1 teaspoonful three or four times daily. SUPPLIED: 4-oz. bottles.

REFERENCES: (1) Bickerman, H. A.: M. Clin. N. America *45*:805, 1961. (2) Bickerman, H. A., & Barach, A. L.: Am. J. M. Sc. *228*:156, 1954. (3) Segal, M. S.; Goldstein, M. M., & Attinger, E. O.: Dis. Chest *32*:305, 1957. (4) Bickerman, H. A. ; German, E.; Cohen, B. M., & Itkin, S. E.: Am. J. M. Sc. *234*:191, 1957. (5) New and Nonofficial Drugs, Evaluation by A.M.A. Council on Drugs, Philadelphia, J. B. Lippincott Company, 1962, p. 453. (6) Bickerman, H. A., *in* Modell, W., ed.: Drugs of Choice 1962-1963, St. Louis, The C. V. Mosby Company, 1962, p. 469, (7) Bickerman, H. A.: Clin. Pharmacol. & Therap. *3*:353 (May-June) 1962. (8) Winter, C. A., & Flataker, L.: Toxicol. & Appl. Pharmacol. *3*:96, 1961. (9) Bickerman, H. A., *in* Modell, W.: op. *cit.*: 474. (10) *Ibid.*: 472.

01263

PROFESSIONAL LIABILITY INSURANCE PROGRAM

officially endorsed by

THE MEDICAL SOCIETY OF NEW JERSEY

PROTECTION for Professional Acts and Professional Premises Liability for members of The Medical Society of New Jersey by the First American Liability Insurance Company.

LOSS CONTROL. Your County Medical Review and Advisory Committee will evaluate malpractice cases and recommend the action which would be most favorable for the Medical Profession, the Defendant Doctor, the Patient and the Public. This program permits understanding of the complex problems involved in such cases and calls for close cooperation between the Medical Profession and Insurance Company.

MEDICO-LEGAL FORMS are furnished to each insured doctor to help in reducing claims or dissatisfied patients. Failure to use forms does not affect the doctor's insurance coverage or his eligibility for insurance.

INSURANCE COUNSELING. Insurance counseling and advice, available at all times, without cost, to help you with your Professional Liability insurance problems.

CANCELLATION. No policy will be cancelled or non-renewed without prior consultation between your Society and the Company and this is a matter of complete cooperation for the best interests of all concerned.

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY

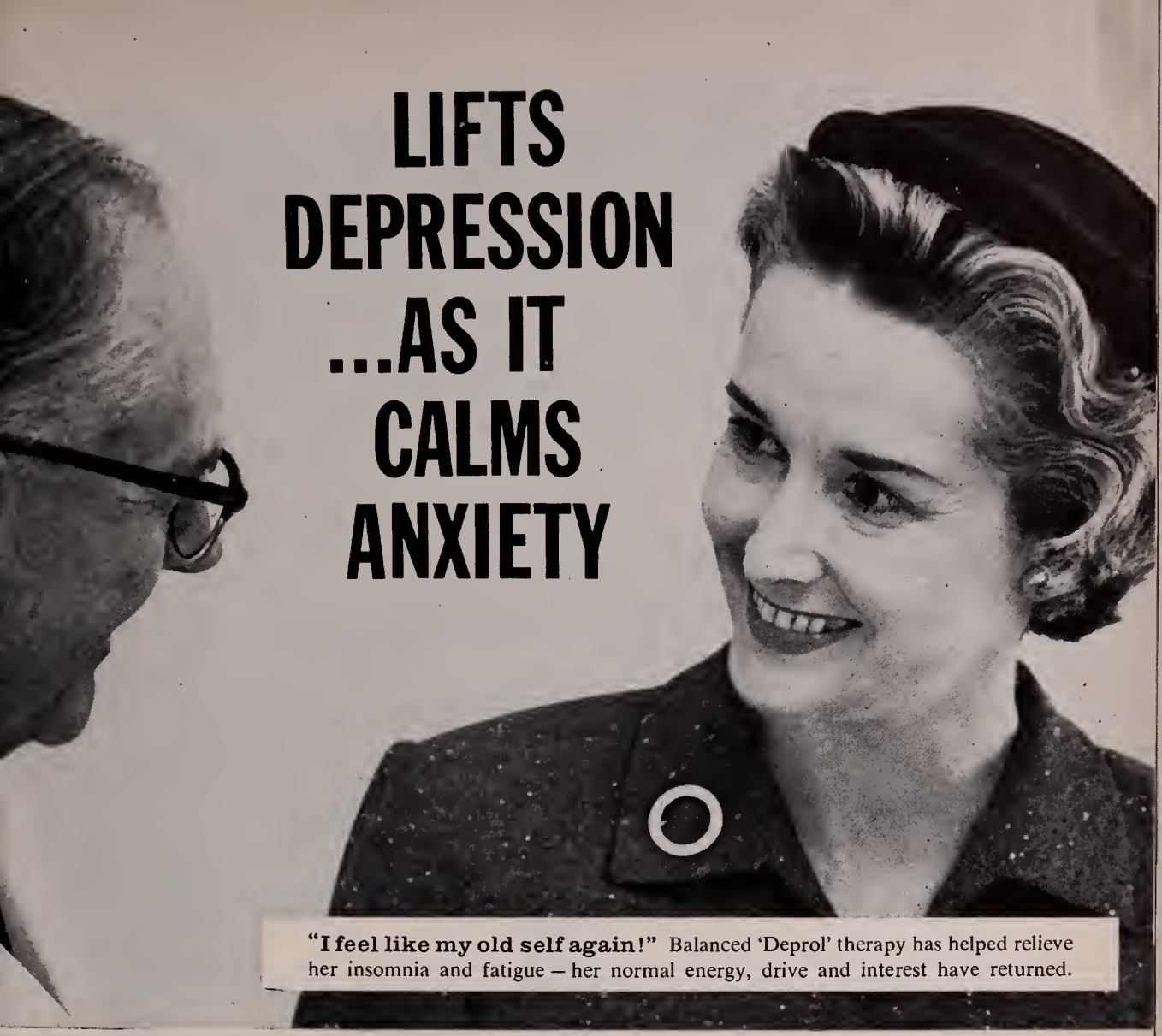
Policies Guaranteed Non-assessable

Professional Liability Department

123 CLEVELAND STREET — ORANGE, NEW JERSEY

Joseph A. Britton, Manager — ORange 3-2575

Home Office: Wakefield, Mass.



"I feel like my old self again!" Balanced 'Deprol' therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

Brightens mood...relaxes tension

Energizers may stimulate the depressed patient, but they often aggravate anxiety and insomnia. Tranquilizers may help the anxious patient, but they often deepen depression. 'Deprol' avoids these "seesaw" effects; it relieves both anxiety and depression. Moreover, it does not cause liver damage, psychotic reactions or changes in sexual function.

Slight drowsiness and, rarely, allergic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

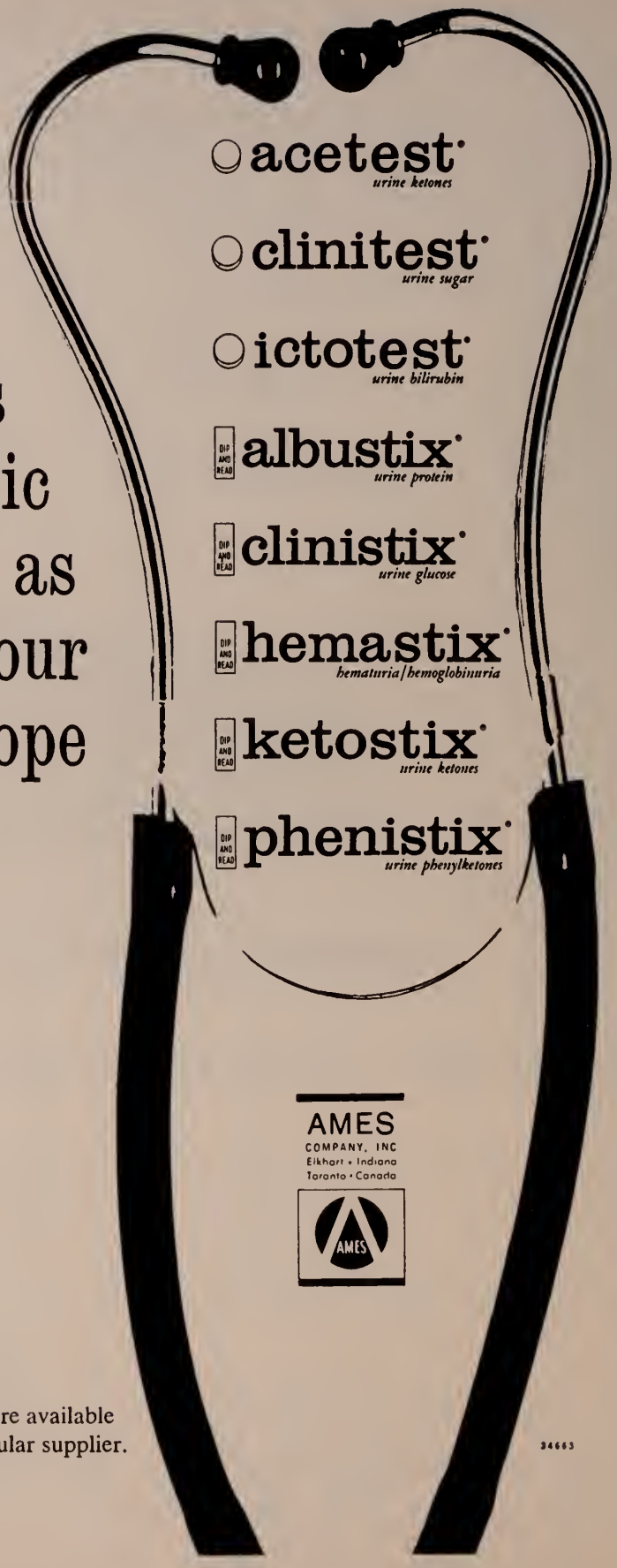
Usual Dosage: 1 tablet q.i.d. May be increased gradually, as needed, to 3 tablets q.i.d.; with establishment of relief, may be reduced gradually to maintenance levels.

▲Deprol▲®

meprobamate 400 mg.
+ benactyzine 1 mg.

WALLACE LABORATORIES / *Cranbury, N.J.*

urine tests as basic as your stethoscope



acetest
urine ketones

clinitest
urine sugar

ictotest
urine bilirubin

DIP AND READ albustix
urine protein

DIP AND READ clinistix
urine glucose

DIP AND READ hemastix
hematuria/hemoglobinuria

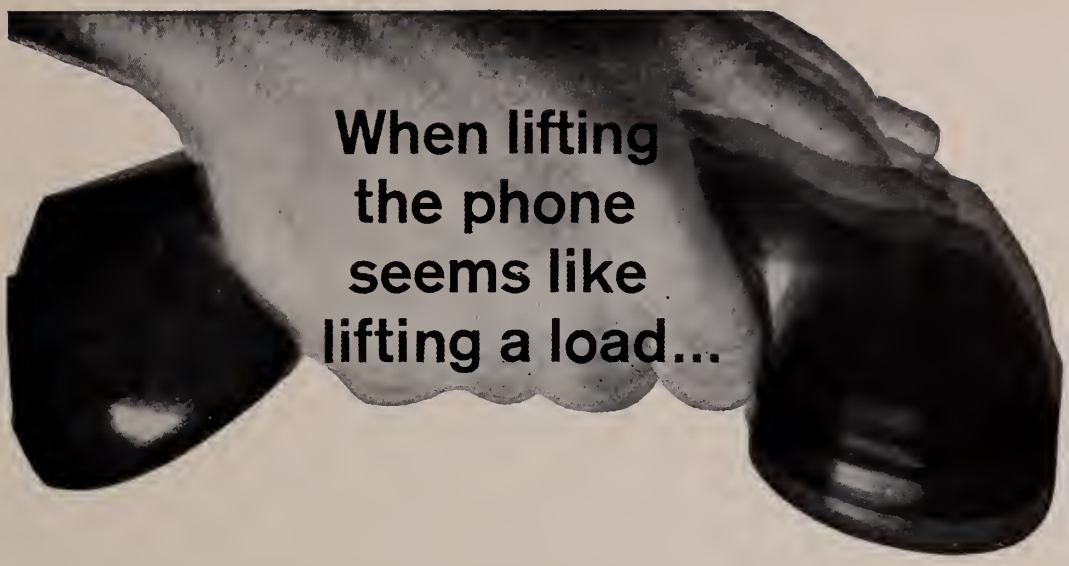
DIP AND READ ketostix
urine ketones

DIP AND READ phenistix
urine phenylketones

AMES
COMPANY, INC
Elkhart • Indiana
Toronto • Canada

AMES products are available through your regular supplier.

34663



in chronic bronchitis and emphysema

ISUPREL® BRAND OF ISOPROTERENOL hydrochloride hydrochloride

MISTOMETER® Q.I.D.

ISUPREL (isoproterenol/Winthrop) "...can increase breathing efficiency in pulmonary emphysema."[1] The patient with chronic obstructive pulmonary disease "...should use the bronchodilator four times daily whether or not he experiences episodes of bronchospasm."[2]

Use of the Mistometer eases breathing by relaxing bronchospasm, and aiding productive cough. "Of the aerosol bronchodilators, ISUPREL (isoproterenol/Winthrop) seems to be the best...."[3] Conscientious use q.i.d. improves vital capacity and exercise tolerance.

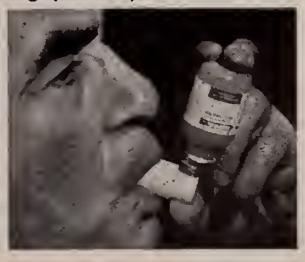
The Mistometer brings new efficacy and convenience—enables patients to maintain treatment wherever they are.

With use of ISUPREL (isoproterenol/Winthrop), occasionally tachycardia, palpitation, nervousness, nausea and vomiting or headache may occur, especially with excessive dosage. Adjust dosage carefully in patients with hyperthyroidism, acute coronary disease, cardiac asthma or limited cardiac reserve, and in persons sensitive to sympathomimetic amines.

Caution: Epinephrine should not be administered with ISUPREL (isoproterenol/Winthrop) as both drugs are direct cardiac stimulants and their combined effects may induce serious arrhythmia. If desired they may, however, be alternated, provided an interval of at least four hours has elapsed.

Dosage: Two inhalations at least one minute apart four times daily, regularly. Inhalations may be taken more often if indicated.

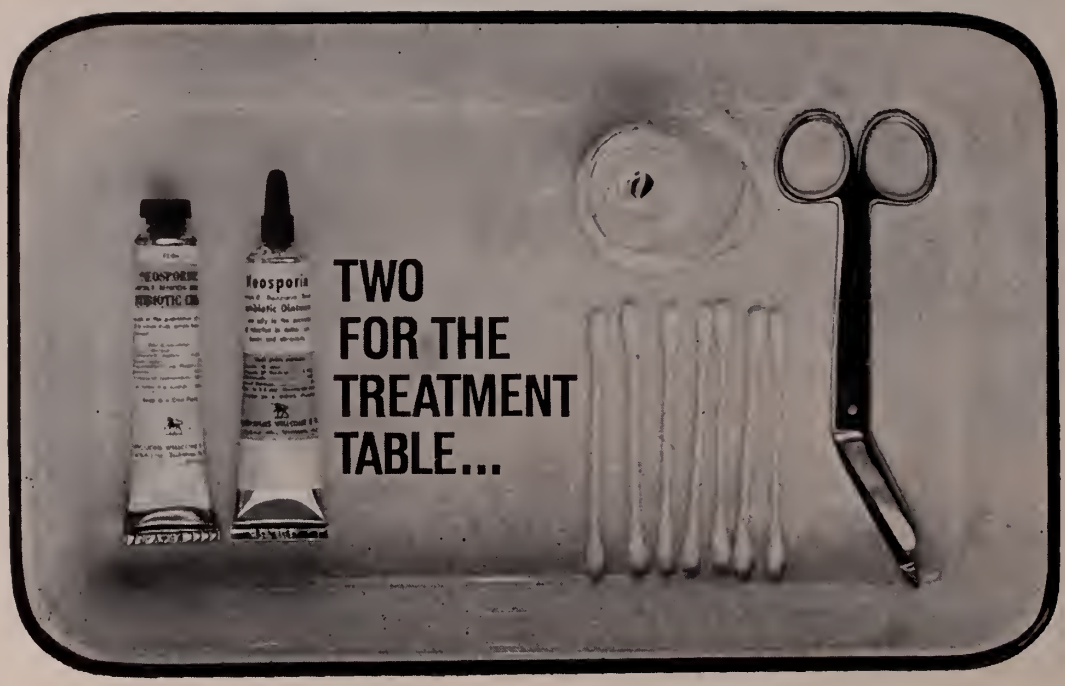
Available as ISUPREL HCl (isoproterenol HCl/Winthrop) Mistometer—single unit combining plastic nebulizer and ISUPREL (isoproterenol/Winthrop) solution 1:400—or 0.25 per cent w/w (=2.8 mg. per ml.), and includes alcohol, 33 per cent; bottles of 15 ml.



1. Reeves, J. E.: *M. Times* 90:512, May, 1962. 2. Williams, M. H., Jr.: *M. Sc.* 11: 433, March 19, 1962. 3. Peckenschneider, L. E.: *J. Kansas M. Soc.* 56:486, Sept., 1955.

Winthrop Laboratories, New York 18, N.Y.

Winthrop



Both the Cream and Ointment rarely sensitize and are bactericidal to virtually all gram-positive and gram-negative organisms found topically, including Pseudomonas aeruginosa and Staphylococcus aureus.

Indications: Wherever infection occurs and is accessible for topical therapy.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

'NEOSPORIN'® brand
POLYMYXIN B / NEOMYCIN / GRAMICIDIN
ANTIBIOTIC CREAM

Ingredients: Each gram contains: 'Aerosporin'® brand Polymyxin B* Sulfate 10,000 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base); Gramicidin 0.25 mg.

In a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, distilled water, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax and 0.25% methylparaben as preservative.

*U.S. Patent Nos. 2,565,057-2,695,261

Available: In 15 Gm. tubes.

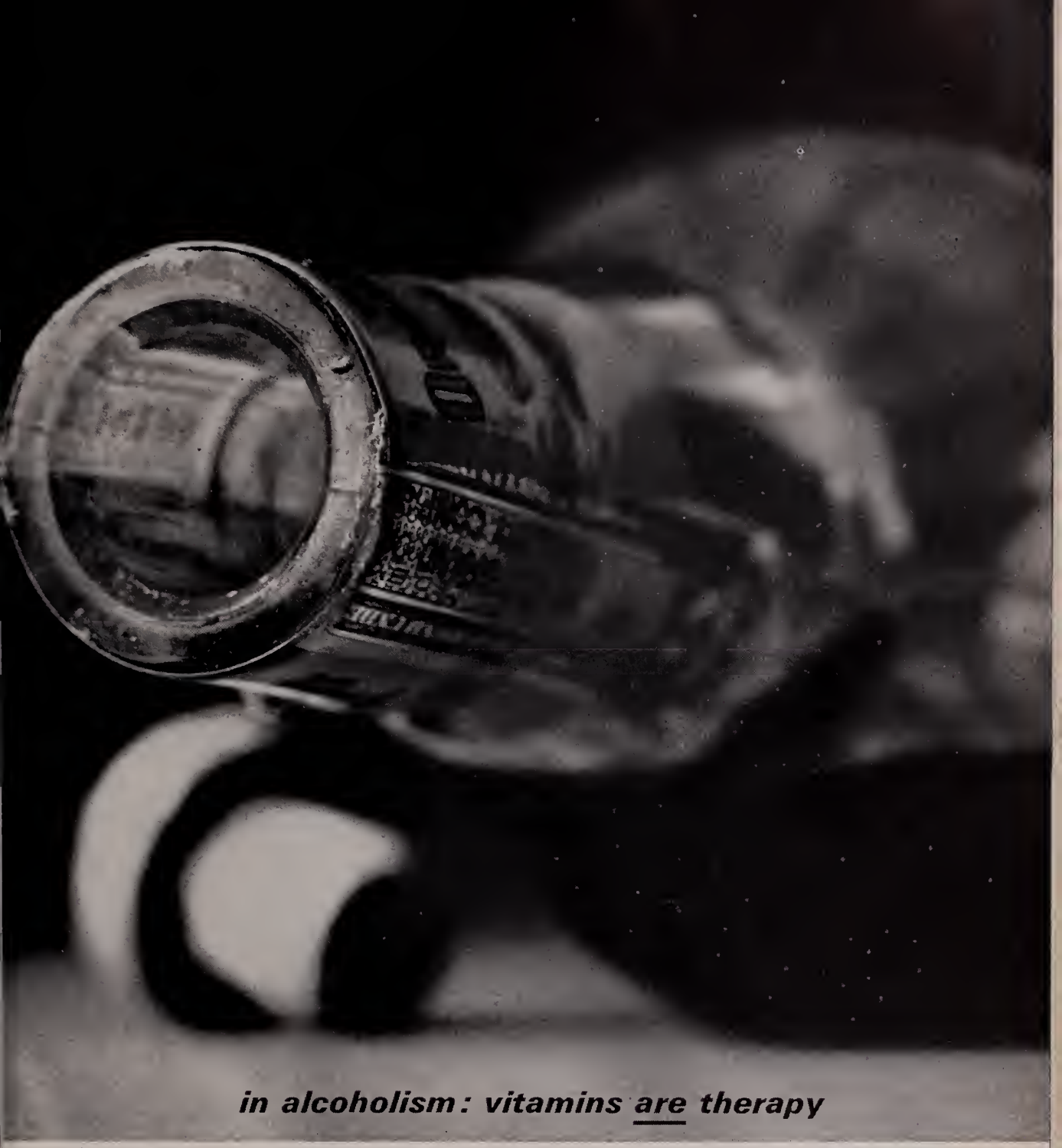
'NEOSPORIN'® brand
POLYMYXIN B / BACITRACIN / NEOMYCIN
ANTIBIOTIC OINTMENT

Ingredients: Each gram contains: 'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units; Zinc Bacitracin 400 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base).

Available: Tubes of 1 oz., ½ oz. and ⅛ oz.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



in alcoholism: vitamins are therapy

A full "comeback" for the alcoholic is partly dependent on nutritional balance... aided by therapeutic allowances of B and C vitamins. Typically, the alcoholic patient is seriously undernourished... from long-standing dietary inadequacy, from depletion of basic reserves of water-soluble vitamins.

FOR PROFESSIONAL RECOMMENDATION ONLY

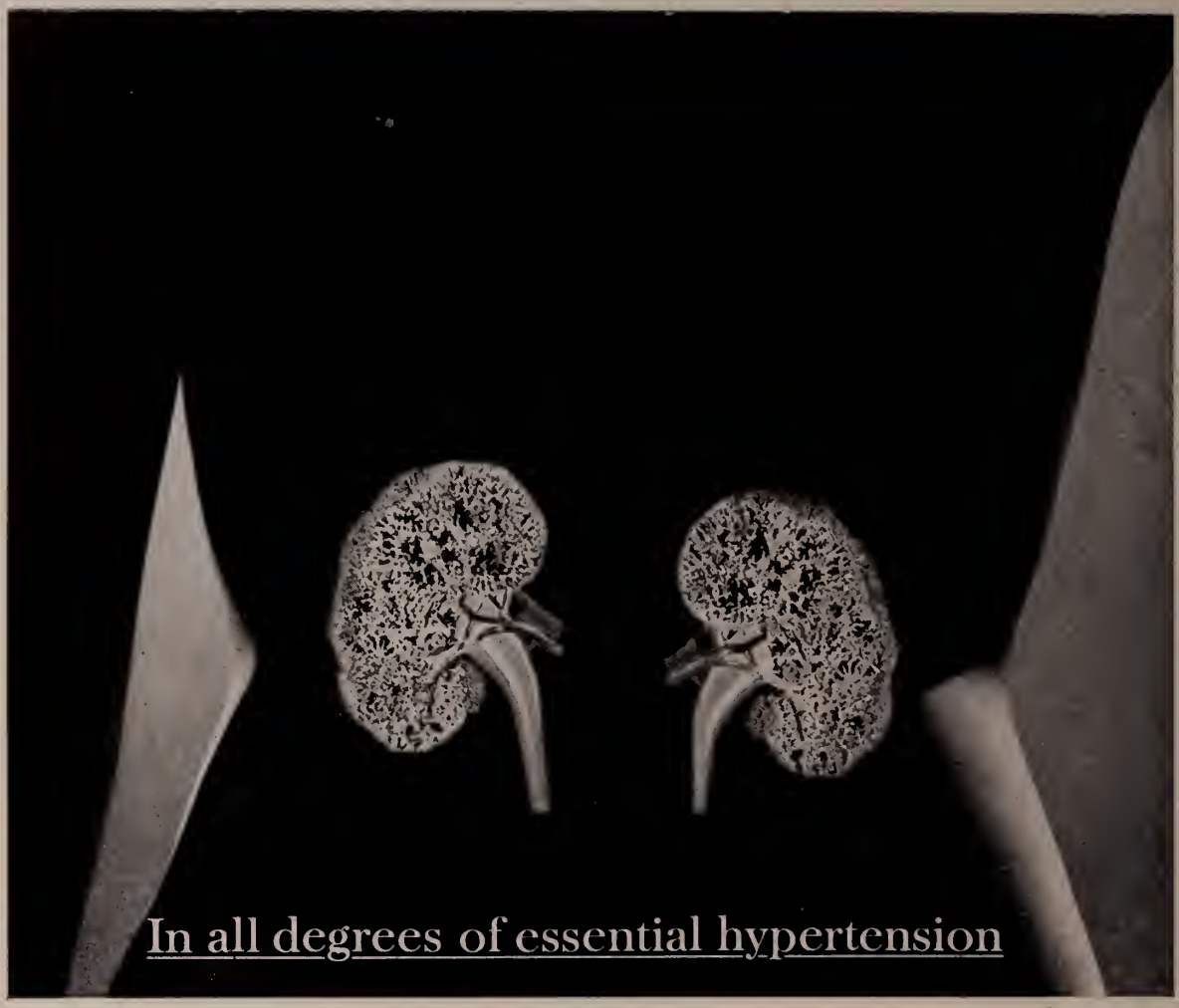
Each capsule contains: Vitamin B_1 (Thiamine Mononitrate)...10 mg. / Vitamin B_2 (Riboflavin)...10 mg. / Niacinamide... 100 mg. / Vitamin C (Ascorbic Acid)...300 mg. / Vitamin B_6 (Pyridoxine HCl)...2 mg. / Vitamin B_{12} Crystalline... 4 mcgm. / Calcium Pantothenate...20 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

6315-3

STRESSCAPS®

Stress Formula Vitamins Lederle



Help protect the kidneys and other threatened organs

When treatment of hypertension is effective the danger of damage to the renal system is reduced.[1-2] "Hypertensive patients suffer from vascular deterioration roughly proportional to the severity of the hypertension... Reduction of blood pressure to normotensive levels reduces or arrests the progress of vascular damage with a resultant decrease in morbidity and mortality."[1] *Because Rautrax-N lowers blood pressure so effectively, it will help provide this important protection not only for the kidneys but also for the heart and brain of your hypertensive patients.* Rautrax-N is effective in mild,[3] moderate,[3,4] or severe hypertension.[4,5]

Dosage: Initially, 1 to 4 tablets daily preferably at mealtime. For maintenance, 1 or 2 tablets daily.

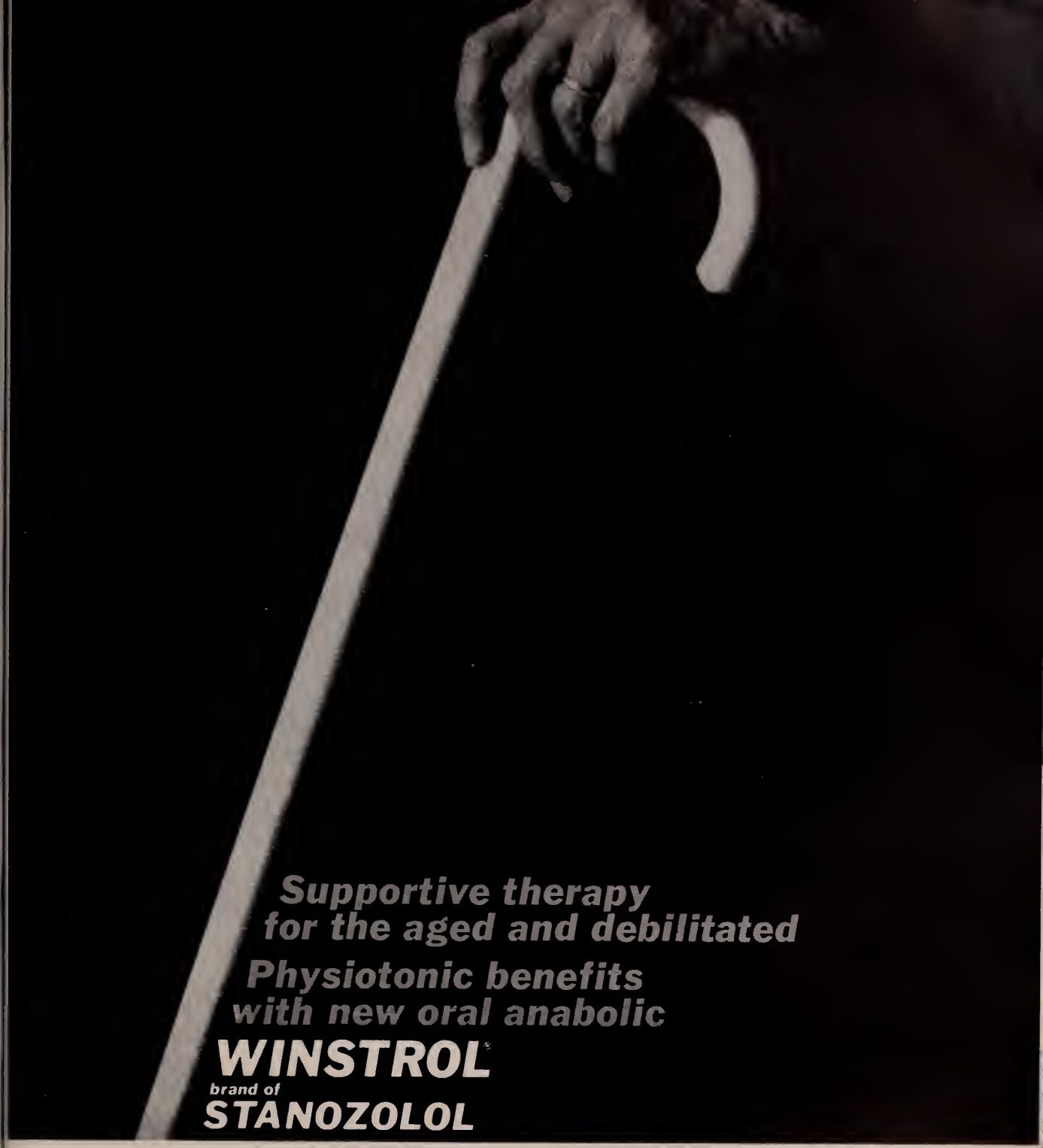
Side effects and precautions: Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression. Caution indicated in use with depression, suicidal tendencies, peptic ulcer. Minor side effects: diarrhea, weight gain, nausea, drowsiness. Bendroflumethiazide may cause reversible hyperuricemia and/or gout, unmask latent diabetes, increase glycosuria in diabetics. Caution indicated in use for patients on digitalis, with severely damaged kidneys, renal insufficiency, increasing azotemia, cirrhosis. Contraindicated in complete renal shutdown. Minor side effects: leg or abdominal cramps, pruritis, paresthesias, mild rashes.

Supply: Rautrax-N—capsule-shaped tablets providing 50 mg. Raudixin® [Rauwolfia serpentina whole root], 4 mg. Naturetin® [bendroflumethiazide], and 400 mg. potassium chloride. *Rautrax-N Modified*—50 mg. Raudixin [Rauwolfia serpentina whole root], 2 mg. Naturetin [bendroflumethiazide], and 400 mg. potassium chloride, in capsule-shaped tablets. For full information, see your Squibb Product Reference or Product Brief.

References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

SQUIBB
Squibb Quality
—the Priceless Ingredient
SQUIBB DIVISION Olin

RAUTRAX®-N RAUWOLFIA SERPENTINA WHOLE ROOT (50 MG.), BENDROFLUMETHIAZIDE (4 MG.) WITH POTASSIUM CHLORIDE (400 MG.), SQUIBB



Notable increase in vigor, strength and sense of well-being

STROL (stanozolol-Winthrop), a heterocyclic steroid, combines nt anabolic effects with outstanding tolerance, stimulates appe- and promotes weight gain... restores a positive metabolic balance. ounteracts the catabolic effects of concomitant corticosteroid or H therapy. WINSTROL (stanozolol-Winthrop) rebuilds body tissue e it builds strength, confidence and a sense of well-being in con- ns associated with excess protein breakdown, insufficient protein ke and inadequate nitrogen and mineral retention.

Effects and Precautions: Prolonged administration can produce l hirsutism, acne or voice change. In an occasional patient, edema been observed and in young women the menstrual periods have n milder and shorter. These side effects are reversible, and pa- ts receiving prolonged treatment should be examined and ques- tioned periodically so that, should side effects appear, the dosag may be reduced or administration of the drug discontinued for a time In patients with impaired cardiac and renal function, there is the pos sibility of sodium and water retention. Liver function tests may revea an increase in bromsulphalein retention, particularly in elderly pa tients. In such cases, therapy should be discontinued. Although it ha been used in patients with cancer of the prostate, its mild androgeni activity is considered by some investigators to be a contraindication

Dosage: Usual adult dose, 1 tablet t.i.d. before or with meals; youn women, 1 tablet b.i.d.; children (school age): up to 1 tablet t.i.d.; chi dren (pre-school age): ½ tablet b.i.d. Available as scored tablets c 2 mg. in bottles of 100. For best results, administer with a high protei diet.

WINTHROP LABORATORIES, NEW YORK 18, N.

arked improvement in appetite / Measurable weight gain Winthrop

"Doctor... I'm so tired all the time"



Lethargic patients respond to Ritalin

(methylphenidate hydrochloride)

When lethargy is a medical problem—in convalescence, chronic fatigue, mild depression, menopause, oversedation, and senility, for example—the gentle stimulant action of Ritalin (methylphenidate hydrochloride) restores normal physical and mental activity.

In his report, Siegler[1] states: "In mild depression or in clinical exhaustion syndromes, a marginal sympathomimetic drug like methylphenidate seems to be the drug of choice for initiating therapy. It does not have the toxic effects found with the amphetamines or with the hydrazines or other antidepressants."

Other significant comments on the clinical safety of Ritalin (methylphenidate hydrochloride): "At no time was there evidence of serious toxic reactions [in a study of 185 patients]. The drug did not produce alteration in blood forming factors, kidney and liver function."[2]

"No significant toxic effects have resulted after the continuous administration of methylphenidate for more than 3 years."[3]

INDICATIONS: Chronic fatigue.

CONTRAINDICATIONS: Marked anxiety, tension, and agitation.

CAUTION: Should not be used to increase mental or physical capacities beyond normal limits. Use cautiously with epinephrine or levarterenol.

SIDE EFFECTS: Nervousness, insomnia, anorexia, nausea, dizziness, palpitations, headache, drowsiness.

DOSAGE: 10 to 20 mg. b.i.d. or t.i.d.

SUPPLIED: *Tablets*, 5 mg. (pale yellow), 10 mg. (pale blue) and 20 mg. (pale orange).

REFERENCES: 1. Siegler, P. E., in Nodine, J. H., and Moyer, J. H. (Editors): *Psychosomatic Medicine*, The First Hahnemann Symposium, Lea & Febiger, Philadelphia, 1962, p. 582. 2. Lapolla, A.: Western Med. 2:383 (Sept.) 1961. 3. Yoss, R. E., and Daly, D. D.: Pediatrics 25:1025 (June) 1960.

2/309BMB

C I B A SUMMIT, N. J.

Ritalin® hydrochloride (methylphenidate hydrochloride CIBA)



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain... not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

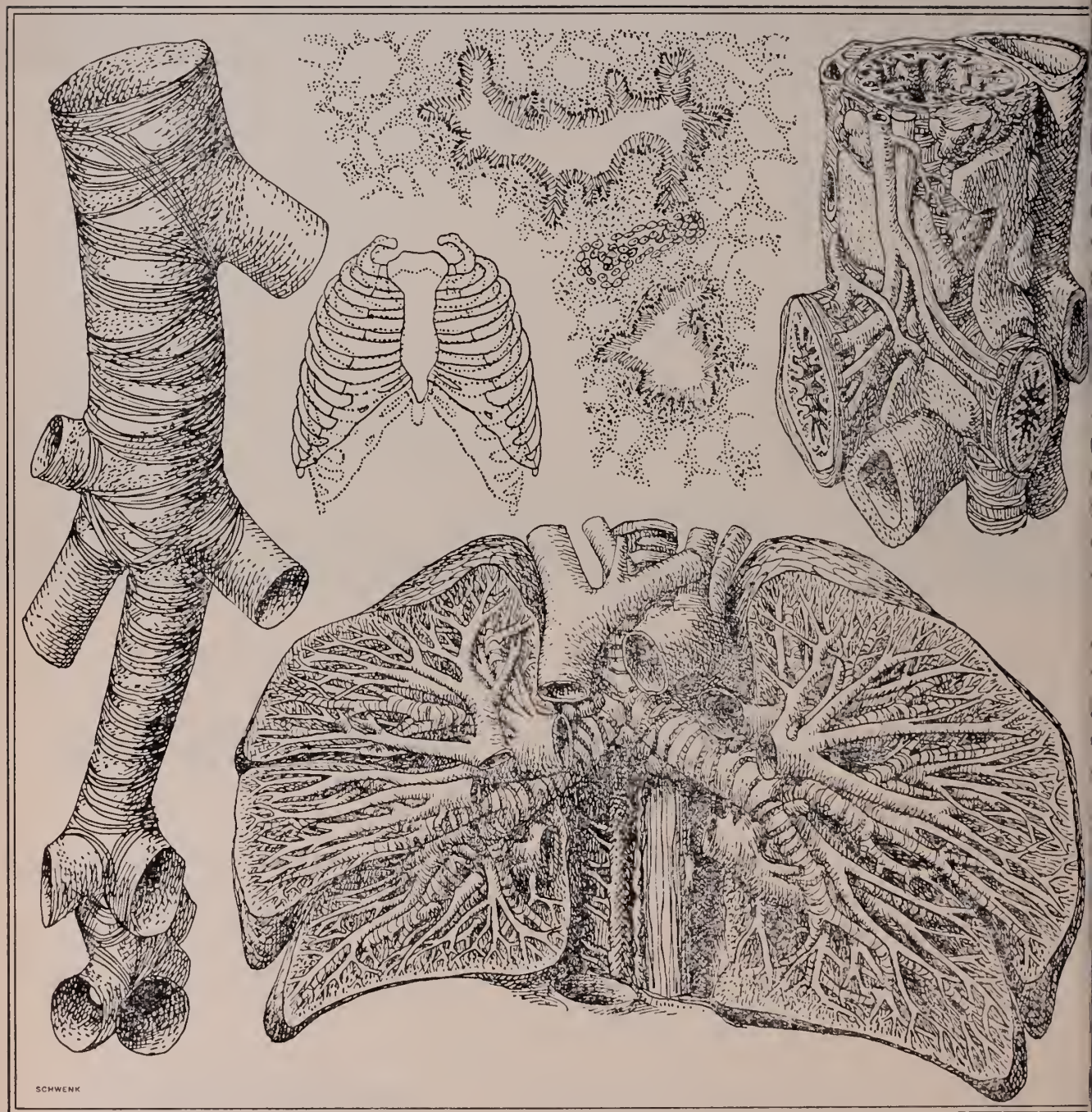
carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

®WALLACE LABORATORIES / *Cranbury, N.J.*

ESO-9193



SCHWENK

Air Rights

With ARISTOCORT Triamcinolone, many asthmatic patients obtain early gratifying relief of wheezing, dyspnea and spasmodic coughing. And maintenance dosage in many cases can be surprisingly low—*often as little as a single 2 mg. tablet per day.* Yet it provides this symptomatic control—which may enable many patients to continue their customary livelihoods or regular household activities—with only minimal interference with other metabolic functions. In this respect, ARISTOCORT Triamcinolone is distinguished compared with other corticosteroids, old and new. Typical steroid problems of sodium retention and edema, euphoria, or voracious appetite and excessive weight gain rarely occur.

ARISTOCORT Triamcinolone is indicated when anti-inflammatory, anti-allergic action of glucocorticoids is desired. SIDE EFFECTS of glucocorticoids generally: Cushingoid effects, hirsutism, leucopenia, purpura, vertigo, fatigue, increased hyperglycemia, osteoporosis, gastrointestinal hemorrhage, cataracts, growth suppression in children and increased intracranial pressure. Other glucocorticoid effects thought more likely to occur with triamcinolone: reversible weakness of muscles and flushing of face.

PRECAUTIONS: ARISTOCORT Triamcinolone should be used with extreme caution in viral infection, particularly herpes simplex and chicken pox, in tubercular or fungal infection, in active peptic ulcer, acute glomerular nephritis or myasthenia gravis.

FORMULA—Tablets (scored) containing 1 mg., 2 mg. or 4 mg. of triamcinolone. Syrup—2 mg. of triamcinolone diacetate per 5 cc. (5 mg. of triamcinolone diacetate is equivalent to 4 mg. of triamcinolone).

Aristocort®
Triamcinolone

Maximum steroid benefits with minimum steroid penalty

Lederle LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York
162-R3 (DC31-S)



STARTING TOMORROW MORNING 

this capsule can help one of your overweight patients do without her favorite (fattening) foods at meals—and during all the hours in between.

Dexamyl® Spansule®

Trademark — brand of sustained release capsules

Each No. 2 capsule contains 15 mg. of Dexedrine® (brand of dextro amphetamine sulfate) and 1½ gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each No. 1 capsule contains 10 mg. of Dexedrine (brand of dextro amphetamine sulfate) and 1 gr. of amobarbital [Warning, may be habit forming].

The active ingredients of the 'Spansule' capsule are so prepared that a therapeutic dose is released promptly and the remaining medication, released gradually and without interruption, sustains the effect for 10 to 12 hours.

INDICATIONS: (1) For control of appetite in overweight; (2) for mood elevation in depressive states.

USUAL DOSAGE: One 'Dexamyl' *Spansule* capsule taken in the morning.

SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

CAUTIONS: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence, in these rare instances withdrawal of medication is recommended. It is generally recognized that in pregnant patients all medications should be used cautiously, especially in the first trimester.

SUPPLIED: Bottles of 50 capsules.

Smith Kline & French Laboratories SK&F *Prescribing information Jan. 1963*



Deltasmyl®

Theophylline (120 mg.)
Ephedrine HCl (15 mg.)
Phenobarbital (8 mg.)
(Barbituric acid derivative)
Prednisone (1.5 mg.)

for safer steroid protection from asthma

DELTASMYL® opens the airways and suppresses inflammation by combining the anti-allergic, anti-inflammatory action of prednisone with the bronchodilating, decongestant and quieting effects of theophylline, ephedrine and phenobarbital.

DELTASMYL provides prompt, prolonged relief of asthma with prednisone protection against allergens and stress, and a wider margin of safety through reduction of the effective corticoid dose.

The aim of therapy in asthma should be relief of bronchospasm by means of decongestant and bronchodilating agents—plus prednisone, not just prednisone alone.[1] Uhde[2]—using theophylline-ephedrine-phenobarbital with prednisone—reports an increase of about 25% in the action of prednisone with quicker arrest of inflammation, hypersecretion, and alveolar stasis; a marked sedative action on heart and circulation; improved ventilation. Bopp[3] also has obtained satisfactory results with the same combination, probably through synergistic enhancement of prednisone potency.

Dosage: One DELTASMYL tablet provides symptomatic relief for 4 hours or longer. Not more than 6 tablets should be taken in 24 hours. Withdraw gradually.

Precautions: DELTASMYL contains ephedrine and should not be given with epinephrine since both drugs may cause tachycardia. Carefully observe patients hypersensitive to sympathomimetic amines. Phenobarbital is a barbituric acid derivative which may be habit forming. Despite the low prednisone dose, all precautions and contraindications of corticosteroids must be heeded, since warning signs such as fluid retention or moon face may not be present. When corticosteroids are given to patients with acute or chronic bacterial infections, appropriate protection should be provided.

Contraindications: Hyperthyroidism, cardiovascular diseases, peptic ulcer, diabetes mellitus, psychotic tendencies, ocular herpes simplex, glaucoma, prostatic hypertrophy, Cushing's syndrome, arrested tuberculosis.

Supplied: Bottles of 50 tablets, on prescription only.

References: 1. Barach, A. L. and Bickerman, H. A.: Pulmonary Emphysema, Baltimore, Williams & Wilkins, 1956, p. 523. 2. Uhde, H.: Med. Monatsschr. No. 8, 505, 1959. 3. Bopp, K. Ph.: Medizinische Klinik 53:186, 1958 and Algerie Medicale 62:1081, 1958.

ROUSSEL

Roussel Corporation

155 East 44th Street, New York 17, N.Y.

Get your low-back patient back to work in days instead of weeks

You can expect rapid results from 'Soma' (carisoprodol)—because this unique drug breaks up both the spasm and pain of low-back syndrome at the same time.

Your patients will usually begin to feel better within a few hours. And as Kestler demonstrated in a controlled study of 212 consecutive patients with low-back problems: the average time for full recovery was only 11.5 days with 'Soma' (carisoprodol), 41 days without it. (J.A.M.A., April, 1960.)

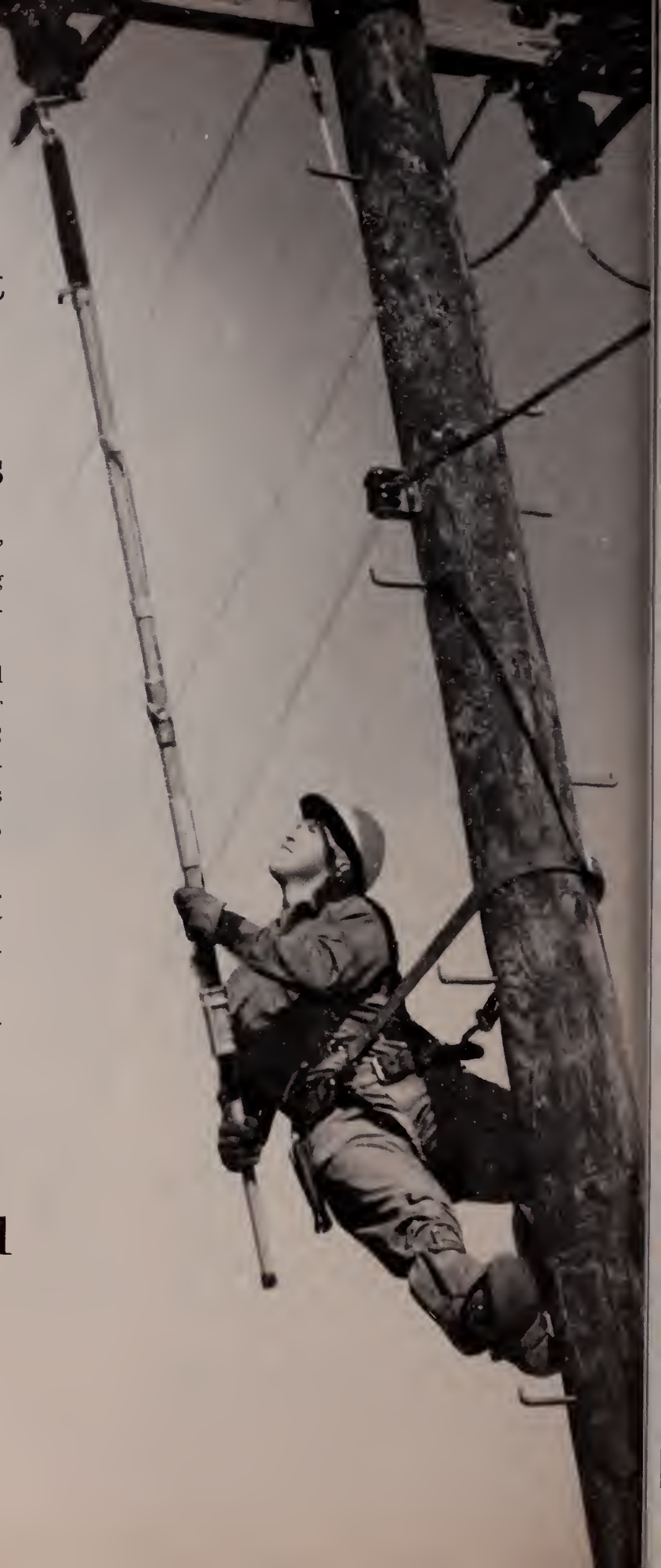
Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely.

USUAL DOSAGE: ONE 350 MG. TABLET Q.I.D.

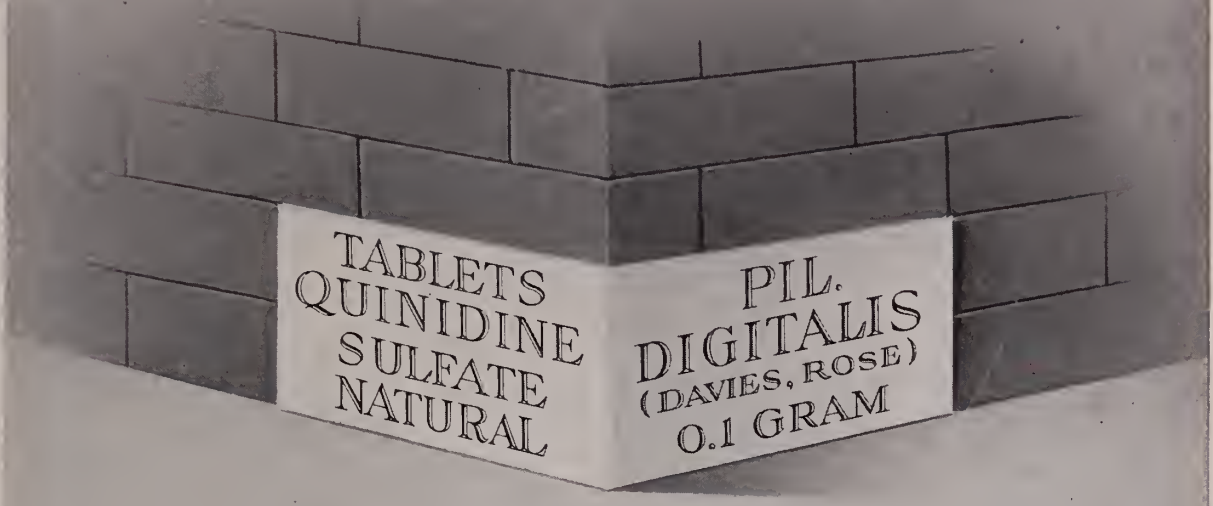
The muscle relaxant with an independent pain-relieving action

Soma®
carisoprodol

Wallace Laboratories
Cranbury, New Jersey



A CORNERSTONE OF CARDIAC THERAPY



The Dictionary defines a cornerstone as something of fundamental importance, just as Pil. Digitalis, (Davies, Rose) and Tablets Quinidine Sulfate Natural (Davies, Rose) are of fundamental importance in treating your cardiac patients. These preparations represent 60 years of experience and dependability in the manufacture of pharmaceuticals.

Pil. Digitalis (Davies, Rose), 0.1 Gram (approx. 1½ grains) which comprise the entire properties of the leaf, provide a dependable and effective means of digitalizing the cardiac patient, and of maintaining the necessary saturation.

Tablets Quinidine Sulfate Natural, 0.2 Gram (approx. 3 grains) are alkaloidally assayed and standardized, insuring uniformity and therapeutic dependability. Each tablet is scored for the convenient administration of half dosages.

Davies, Rose & Company, Limited - Boston 18, Mass.

pq-2

Milestones in Nutrition

1915 when B vitamins were missing...

. . . they turned to milk. In 1915 McCollum and Davis found that there was a water-soluble growth factor present in dried milk and wheat embryo. They called it "vitamin B."

Today "vitamin B" has grown into a family of vitamins: thiamin . . . riboflavin . . . niacin . . . pantothenic acid . . . vitamin B_6 . . . biotin . . . choline . . . folic acid . . . and vitamin B_{12}. Some members of the family . . . thiamin and niacin . . . have been found to prevent major diseases of man . . . beri-beri and pellagra. Others . . . folic acid and vitamin B_{12} . . . are effective against diseases of the blood . . . pernicious anemia and sprue.

No one food is rich in all the B vitamins. These nutrients are best obtained by consuming recommended amounts of the four main food groups . . . dairy foods, meats and eggs, vegetables and fruits, bread and cereals. Milk and dairy products . . . 3 to 4 glasses for children and 2 glasses for adults . . . make a balanced contribution to the supply of the B complex vitamins.

As they have in the past, milk and other dairy foods will continue to play a vital role in the nutritional welfare of our people.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.



Since 1915 . . . promoting better health through nutrition research and education

NATIONAL DAIRY COUNCIL

a non-profit organization

202 EAST 44TH STREET • NEW YORK 17, NEW YORK

AVAILABLE ON REQUEST: Reprints of this series of messages on "MILESTONES IN NUTRITION" and "CLINIC LEAFLETS" ON PRE-NATAL, POST-NATAL, AND INFANT CARE

blood, milk and Maalox®

(magnesium-aluminum hydroxide gel)

Practically standard treatment, now, for perforated ulcer. Why is Maalox included? Antacid therapy *must* continue long after the wound has healed, and patients started on Maalox tend to stay on Maalox. It tastes good; it's effective and will not cause constipation – three important reasons for Maalox over the long haul. Some physicians, we are told, order Maalox routinely for hospital patients on drugs which could irritate. They feel it reduces the likelihood of gastric discomfort. Supplied: Suspension; Tablets No. 1; Tablets No. 2. (Each Maalox No. 1 Tablet is equivalent to 1 teaspoonful and each Maalox No. 2 Tablet is equivalent to 2 teaspoonfuls of Suspension.)



RORER

WILLIAM H. RORER, INC., FORT WASHINGTON, PA.



NTz Nasal Spray gives prompt, dependable decongestion of the nasal membranes for fast symptomatic relief of hay fever. The first spray shrinks the turbinates, restores nasal ventilation and stops mouth breathing. The second spray, a few minutes later, improves sinus ventilation and drainage. Excessive rhinorrhea is reduced.

NTz Nasal Spray also provides decongestive relief for head colds, perennial rhinitis and sinusitis. Supplied in leakproof, pocket-size, squeeze bottles of 20 ml. and in bottles of 30 ml. with dropper.

NTz® Nasal Spray

NTz is more than a simple vasoconstrictor. It contains [N]eo-Synephrine® HCl 0.5%—the efficacy of which is unexcelled—to shrink nasal membranes and provide inner space; [T]henfadil® HCl 0.1% for topical antiallergic action; and [Z]ephiran® Cl 1:5000 (antibacterial wetting agent) to promote the spread of the decongestant components to less accessible nasal areas.

NTz is well tolerated and does not harm respiratory tissues.

NTz, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium as chloride, refined), trademarks reg. U. S. Pat. Off. 1795M

Winthrop Winthrop Laboratories
New York 18, N. Y.



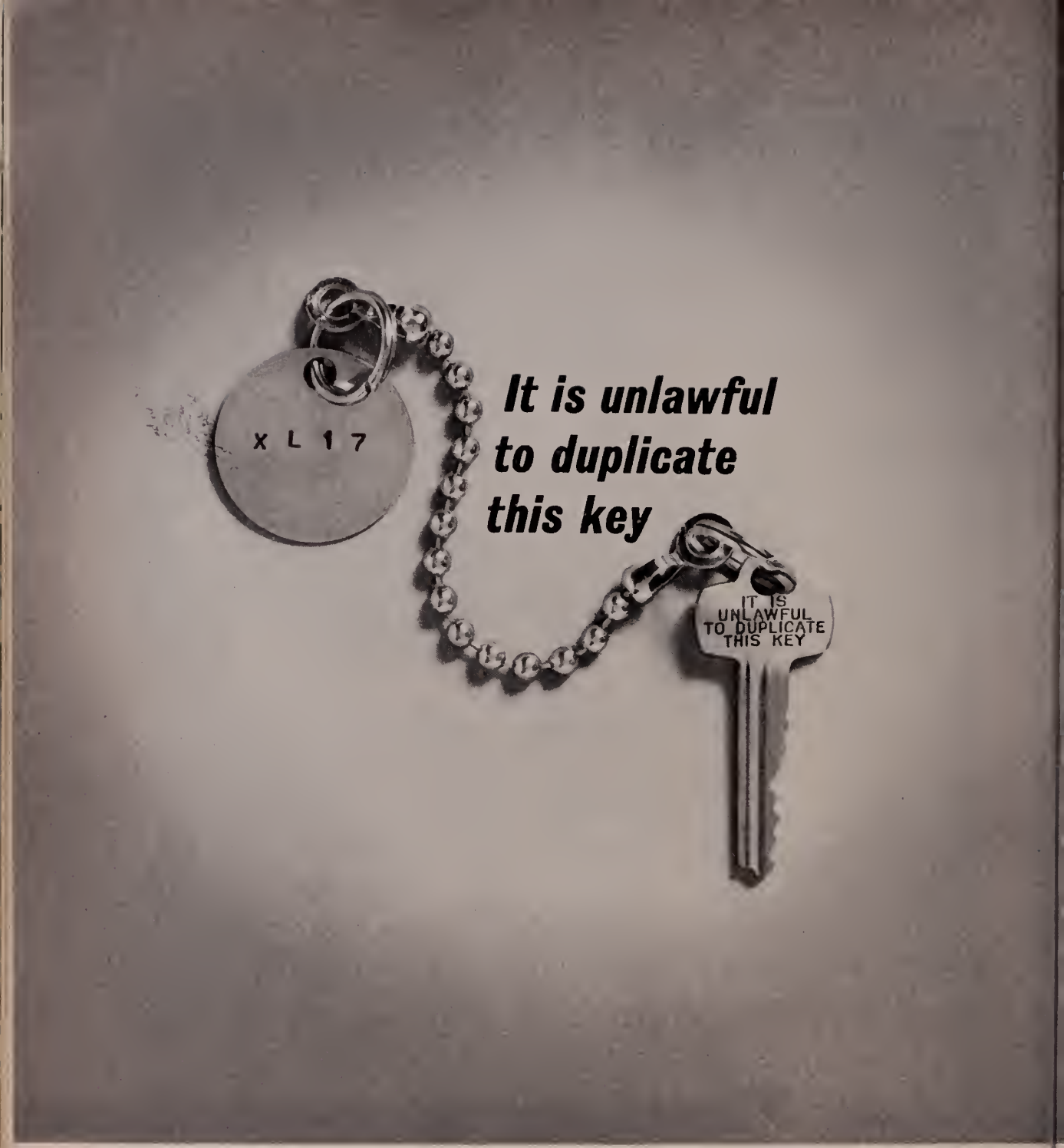
HOW TO BE SURE
your young patients get the aspirin dosage you want them to have

The answer is Orange Flavored Bayer Aspirin for Children

The dosage is 1¼ grains per tablet. Mothers place such confidence in the Bayer name. And the new orange flavor is so fresh and smooth that children take it readily. (The grip-tight cap on the bottle helps keep them from taking it on their own.)

For professional samples, just write The Bayer Company, Dept. 112 1450 Broadway, New York 18, New York.





This is the key that opens the box that contains the labels. Only authorized supervisory personnel have the key to transfer labels from the "lockup box" to the labeling machine. ■ These responsible Lilly employees regard labels as serious business. To make certain that the right label appears on each container, all labels are kept under lock and key until needed on the finishing line. Only the quantity needed to finish the lot is dispensed. When transferred to the finishing belt, the appropriate number of labels is placed in the labeling machine. Excess labels are put in the lockup box until needed. At night, the supervisor returns unused labels to the box lest some get lost or misplaced. ■ This is just one more precaution in an endless list of rules that contribute immeasurably to the quality of the finished product.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

300142

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Research Without Animals

Someone ought to devise a salute to mice and monkeys, rabbits and rats, and all the other actual and eponymic guinea pigs of the animal world. Without them, pharmaceutical research would ground to a halt. Either that, or it would be transformed from a scientific pursuit into a deadly gamble.

Imagine a pharmaceutical research laboratory without animals. The chemists synthesize a new drug, and on theoretical grounds it ought to work. Or they make a synthetic drug which exactly mimics the structural formula of a biological. Can they then ask the physician to try it on a human being? Toxicity cannot be measured *in vitro*.

Of course there are limitations. Animals cannot be analogized 100 per cent to human beings. Animal physiology is not, shall we say, on all fours with human physiology. But the similarities are startling and the experience of the last few decades has shown amazing ability to translate findings from lower animals to applicability to *homo sapiens*. The development of steroids, vitamin concentrates, energizers, hypotensive agents, cardiac drugs and diuretics, for instance, has been made possible through animal experimentation—through findings which *did* survive the species barrier when the drugs were given to humans. The major difference is in the field of behavior and emotions. Even there, though, much of our knowledge of tranquilizers and energizers has come through animal experimentation.

The fantastic progress made in pharmaceutical chemistry since 1930 has been due in large measure to the availability of the unsung heroes of the living world: experimental animals.

Published Monthly Since 1904 Henry A. Davidson, M.D., Editor
Under the Direction of the Committee on Publication Theresa E. Goeke, Assistant Editor
George B. Sharbaugh, M.D., Chairman
Place of Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton, N. J. 08605 — EXPORT 4-3154
Send all communications regarding advertising to Joseph W. Cookson, 370 Morris Ave., Trenton, New Jersey 08611 — EXport 3-7196
Each member of the Society is entitled to receive a copy of The Journal every month
Whole Number of Issues 709

Vol. 60, No. 9 SEPTEMBER, 1963 50 Cents - $5.00 per year

In the Palm of Your Hand

"Blue Shield holds in the palm of its hand the survival of professional freedom in this country." So declared Dr. Norman A. Welch in a recent address, and there are few thoughtful students of the medico-economic scene who would disagree with him. Dr. Welch is a former Chairman of the Board of the National Association of Blue Shield Plans and now is Speaker of the American Medical Association House of Delegates.

If the survival of professional freedom depends on Blue Shield, it is equally true that the survival of Blue Shield depends on the medical profession—on our willingness to face the facts of life and to support realistic solutions for the problems we confront.

A good Blue Shield program—one that our patients will not only accept but defend—provides for lower and middle income families an assurance of fully prepaid service benefits for a broad spectrum of professional services. Mere cash indemnity benefits—unrelated to the fair value of needed professional services—are not enough. If medicine had not embraced the principle of dependable service benefits in most Blue Shield programs, the voluntary medical prepayment program would have died aborning, and we would be operating under a state-dominated plan of medical care today.

Fortunately for us—and for the American people—Blue Shield is on the march. Indeed, Dr. Welch prophesies that "we will shortly see the day when it would take a great deal of courage to criticize Blue Shield because of the respect of the public for what we are trying to do. By your participation in such a respected program you will do more to preserve the private practice of medicine than by any other single effort on the physicians' part."

Chirurgeon Kai Cephalurgeon

The Greeks had two words for it. *Cheir* meant hand. *Ergon* meant work. *Chirurgeon* was, therefore, one who worked with the hands. And *doctor* ("docere": to teach) was the well taught man, the learned one. So it was for many centuries. The surgeon (*chirurgeon* in modern dress) was the craftsman; the physician was the man of learning who worked with the brain. (Originally, indeed, *physician* meant natural philosopher with the accent on the second word.)

It is now an archaic distinction. The surgeon has travelled a long way from his humble ancestry. For one thing, now that even the living heart can be the subject of his skill, no organ, no tissue is inaccessible to his scalpel. Then, too, there is the high degree of diagnostic skill involved, the ability to weigh body fluid metabolism, subtle points of differential diagnosis, the personal response to anesthesia, a keen insight into the physiology of shock, a grasp of the histologic nature of human repair, the engineering principles of the heart-lung machine and the willingness to assume the awesome responsibility of having human life quite literally in one's hands.

No one man can be that great an artist, possess that vast a learning. If team work ever meant anything, in surgery today it means everything. Not only the team hovering around the operating table, but also the backstopping of the surgeon's judgment and skills by the medical consultants, the pathologist, the nursing staff in the wards, the technicians, the anesthesiologists, and the diverse specialists who are needed to understand the most complex machine in the world. A practitioner who must know about immune mechanisms, ion exchanges, personality disintegration, heavy water, neurophysiology, and human metabolism is no longer a craftsman. He works not just with the hands, but also with the head: *chirurgeon kai cephalurgeon.*

Seymour F. Kuvin, M.D.

Morristown

The Smoking Habits of School Children*

It seems hard to believe that a third of our fourteen-year old girls are now smoking—but Dr. Kuvin's survey suggests that this is so.

Cigarette smoking has become commonplace among school children.[1] Many teachers say that it is not unusual to see pubescent children smoke. This observation led to a survey of children in the pubescent and beginning adolescent age group to determine the following:

1. The incidence of smoking by children in this age group.
2. Reasons for this smoking, if any could be determined.
3. How many cigarettes each child smoked daily.
4. Awareness of the possible dangers of smoking.
5. Did children who smoked have parents who smoked.

The survey was made in the Morris Township Junior High School, which has a student population of about 450. We received 421 returns. These students are distributed over the seventh, eighth, and ninth grades. Average age in these grades is 12, 13, and 14 years, respectively. The community it serves is a representative, small municipality with children from diverse economic, educational, and cultural backgrounds.

RESULTS

All questions were answered on an unsigned questionnaire. The students were told of the need for accuracy. The anonymity of the answers was emphasized. There was no communication between students.

Results are shown in the tables. Ten per cent of the seventh grade boys, 16 per cent of the eighth grade boys, and 17 per cent of the ninth grade boys smoke. Only 5½ per cent of the seventh grade girls and 5 per cent of the eighth grade girls admitted smoking, but 31 per cent of the ninth grade girls said they did. Hence, smokers comprise 8 per cent of the seventh grade, 12 per cent of the eighth grade, and 24 per cent of the ninth grade.

The number of cigarettes smoked daily was relatively low in all grades, but the amount increased with the age of the student. This is illustrated in Table 2. The accuracy of these numbers is questionable, since many students often take puffs of other persons' cigarettes.

Most students did not know why they smoked. Many did not answer when asked the reason for smoking, or frankly stated that they didn't know. An almost equal number stated vaguely that they liked or enjoyed smoking. Reasons are summarized in Table 3. Note the relatively large number who asserted a tranquilizing effect.

Unfortunately, less than half of the smokers were aware of any increased incidence of lung cancer in people who smoke. Four students actually stated that they knew it was not harmful.

Fourteen per cent of the smokers came from families where neither parent smoked. At least one parent was a smoker in most instances.

*For their assistance in this survey, I am indebted to the faculty of the Morris Township Junior High School.—S.K.

1. Morison, J. B. and Medovy, H.: Canadian Medical Ass. Journal, 84:1006 (June 1961).

DISCUSSION

The correlation between smoking and lung cancer, heart disease, and other physical disorders is well known and has been repeatedly demonstrated.[2] Many young school children are smoking. These children are neither aware of their reasons for smoking, nor did they know of the inherent dangers.

There has been apathy in the attitude toward the smoking of cigarettes by school children. This is apparent among parents, educators, medical personnel, and others concerned with the health and welfare of children. Perhaps the reason for this apathy is that many of these adults are smokers themselves. They have ignored or rationalized away the dangers of smoking. An adult smoker is not the person to present the hazards of smoking to the school child: it is akin to the sinner ascending the pulpit.

To present the dangers of smoking to the student is an easy task. It is more difficult to set the example. This requires that the smoking adult erase an established habit that may be easier to retain. Another reason for the adult smoker to abstain becomes apparent.

SUMMARY

A survey was done in a representative small municipality to determine the incidence of smoking among children in the 12 to 14 age bracket. This indicated that 15 per cent of the boys and 17 per cent of the girls smoked. In the 9th grade (average age: 14) a third of the girls smoked.

TABLE 1.

Total	Grade	7th	8th	9th
421	Average age	12	13	14
31	Boys who smoked	6	13	12
180	Boys who did not smoke	54	68	58
15%	Per cent boys who smoked	10%	16%	17%
31	Girls who smoked	3	4	24
179	Girls who did not smoke	51	75	53
17%	Per cent girls who smoked	5%	5%	31%
62	Children who smoked	9	17	36
16%	Per cent children who smoked	8%	12%	24%

TABLE 2.

No of Cigarettes Consumed by Smokers	Grade Students 7th	8th	9th
Less than 7 a week	8	10	23
1 to 6 a day	1	4	9
6 to 10 a day	0	3	4

(None smoked more than ten a day)

TABLE 3.

ANSWERS TO QUESTION:
WHY DO YOU SMOKE?"

20	did not answer or said that they did not know	31%
19	said "I enjoy it" or "I like to"	30%
12	found it soothing or relaxing	21%
3	said it was "just a habit"	5%
3	said "just wanted to try it"	5%
5	said "the crowd does it"	8%
62		100%

TABLE 4.

ANSWERS TO QUESTION:

"ARE YOU AWARE OF ANY DANGER IN SMOKING?"

24	said generally "yes"	38%
28	specified "cancer"	45%
4	said "affects heart and lungs"	7%
2	said "it harms health"	3%
4	said that it was not dangerous	7%
62		100%

TABLE 5.

PARENTS OF SMOKING CHILDREN

14	Neither parent smokes	22%
22	Both parents smoke	35%
26	One parent smoked	43%
62		100%

TABLE 6.

PARENTS OF NON-SMOKERS

Only Mother Smokes	Only Father Smokes	Both Parents Smoke	Neither Parent Smokes
51	54	115	139

2. For example, in Anderson, D. and Ferris, B.: New England Journal of Medicine, 267:787 (1962); *and in* Finkelstein, M.: Journal of The Medical Society of New Jersey, 57:616 (May 1960); *and in* Thomas, C. B.: Annals of Internal Medicine, 53:697 (1960).

22 Washington Avenue

Louis F. Raymond, M.D

East Orange

Ocular Pathology in Reserpine Sensitivity

Report of Two Cases

Potent medicines often have side effects. Blood pressure reduction can sometimes be achieved at too high a price.

The reserpine alkaloids are valuable hypotensive agents. But they also can sensitize the central nervous system. Here are two cases in which sensitivity to these alkaloids seems to have produced serious ocular pathology. Then the optic atrophy, hypertensive retinopathy, grade four, Fuchs' heterochromia of the iris, secondary glaucoma, hyphemia, cataracts, plus acoustic nerve neuropathy and dulling of the sensorium were all reversed upon discontinuing the drug. In a similar case, the drug was continued; complete optic atrophy with loss of light perception and hearing loss were end results. These cases confirm the report of Freedman and Benton [1] that reserpine alkaloids sensitize the central nervous system after two or more doses. It also confirms the observations of Hollister,[2] who noted hemorrhagic diathesis by causing purpura, melena, and hematemesis, and aggravation of allergic conditions.

CASE ONE

A 60-year old woman was first seen in consultation on December 9. Best corrected vision at this time was 20/100 (right) and 20/60 (left). Intraocular tension, right, was 45 mm. Schiotz (S); left eye, 30 mm. Schiotz (S). The right eye also had active Fuchs' heterochromic iritis and ectropion uvea. The pigment was visible in the anterior chamber in the inflammatory process, with added pigment deposits on the posterior cornea. Medical history showed hypertension, moderate essential; 180/100. Her family physician had prescribed reserpine (0.25 mg.) twice daily. This drug had been taken previously and discontinued.

The clinical central nervous system sequellae ensued upon use of the drug for the third time. Intervals between discontinuance and use of reserpine varied between four weeks to four months. Ophthalmologic treatment consisted of local steroids, miotics, and epinephrine bitartrate. Three weeks later, best vision was R.E.: 20/200; L.E.: 20/80. Intraocular pressure remained uncontrolled as well as the anterior uveitis and retinopathy. The ocular inflammatory process continued to the point of pupillary block with corneal edema. The reserpine was discontinued at this time. The inflammatory process showed gradual improvement. Two months later, best vision was 20/40 in each eye; by this time, the iritis and the glaucoma had subsided, and the retinopathy had cleared. Periodic observation over a five-month interval showed no essential ocular changes. The blood pressure never exceeded 140/90; no systemic medication was used.

In July (six months after I first saw her) she resumed the reserpine. Vision was now reduced to 20/60 and 20/50. Intraocular tension increased to (R.E.) 60 mm. (S); and (L.E.) 30 mm. Schiotz. She was gradually developing a progressive hearing loss and a dulling of the sensorium. Progress over the next nine months was poor. Visual fields became constricted. Intraocular tension remained elevated; cataracts developed. Vision was reduced to light perception on the right and to 20/100 on the left. Physically, the hearing loss was more apparent; vertigo and dulling of the sensorium was more pronounced.

1. Freedman, A. and Benton, B.: New England Journal of Medicine, 264:11 (March 16, 1961).
2. Hollister, C.: New England Journal of Medicine, 264:345 (December 1960).

A cataract extraction was done 1½ years later. Postoperative course was uneventful. No reserpine was used in the hospital for one month; then, such medication was added to her systemic treatment. Symptoms swiftly followed; increased intraocular pressure, vertigo, hearing reduction, visual reduction.

The poor progress following reserpine therapy was noted repeatedly. In March 1961, my findings were supported by Freedman and Benton,[1] and reserpine ordered permanently discontinued.

The patient improved; hearing was restored to the point of normal conversation; sensorium improved; intraocular tension returned to normal; the uveitis cleared; the retinopathy subsided. The vision in the right eye was nil; optic atrophy is present. The left eye corrected to 20/30. No local or systemic medication has been used for one year.

CASE TWO

A 67-year old woman was first seen for a red, irritated eye. She was referred by her family physician who was treating her for hypertension with therapeutic doses of reserpine. She was on the medication for over six months.

Blood pressure was 160/80. The vision was reduced to finger count at three feet in each eye. The right eye had a steamy cornea, hyphemia and glaucoma 60 mm. Schiotz (S). This eye also showed optic atrophy and hypertensive retinopathy. Ophthalmologic treatment included steroids locally, miotics, and carbonic anhydrase inhibitors, systemically. The physical conditions were re-evaluated with no significant findings.

She was observed over a nine-month interval. Her progress varied little, until she gradually had loss of vision, auditory sensations were severely diminished, and the sensorium was dulled.

Two months later, she had optic atrophy in each eye, uncontrolled secondary glaucoma and uveitis. In addition, the hearing was severely reduced; and the sensorium diminished.

Reserpine had never been discontinued for over one year. No systemic or local therapy could reverse the pathologic process.

Case No. 1 confirms the observations of Freedman and Benton[1] and Hollister[2] that reserpine alkaloids do sensitize the central nervous system. The sensitization includes the uveal tract of the eyes.

On repeated occasions in therapeutic doses, auditory, ocular, and general central nervous system sensitivity phenomena occurred. In each instance, on withdrawal of the drug, the pathology reverted to relatively normal findings. Earlier withdrawal of the reserpine would probably have prevented optic atrophy in the right eye.

The pathology of the ocular inflammatory process was a hemorrhagic diathesis illustrated by a grade four retinopathy. The eye fundus showed hemorrhages, exudates, and edema. The anterior uveal inflammatory process produced a pigment migration which was visible grossly and with the slit lamp microscope. The increased protein in the anterior chamber apparently was due to the increased capillary permeability of the anterior uveal vessels. The iris was pushed forward into the anterior chamber so that the chamber was almost obliterated. All the tissues in the uveal tract were edematous; the crystalline lense became opaque.

Systemic carbonic anhydrase inhibitors, local medication steroids, miotics, adrenergic drugs had very little effect on the pathologic process. Withdrawal of the drug, however, was effective in a gradual reduction of the inflammatory process, and absorption of the hemorrhages of the retina and the hyphemia was present in the anterior chamber.

The pathologic ocular process is apparently an allergic mechanism. Edema, hemorrhage, increase vascularity with increased permeability of the capillaries and arterioles are concluded by careful observation grossly and with the corneal microscope. In view of additional clinical signs of central nervous system involvement, the pathology must be a manifestation of the entire central nervous system. Therefore, additional supporting evidence is added to Freedman, Benton[1] and Hollister's[2] excellent observations of a dangerous drug.

The second case illustrates the sensitivity phenomenon of the central nervous system. It accidentally served as a control. The drug was never withdrawn. A progressive central nervous system deterioration resulted; that is, total optic atrophy, severe hearing impairment, and generalized dulling of the sensorium also occurred. Systemic and local therapy did not alter the pathologic process of the sensitivity reaction. Early withdrawal of the drug appears to be the only effective method for a favorable prognosis.

SUMMARY

Two cases are reported to show the eye pathology, in central nervous system sensitivity, of reserpine alkaloids. One case unintentionally served as a control; the other was reversible upon discontinuing the drug. No other system of therapy was successful. The eye findings were optic atrophy, retinopathy, heterochromia of the iris, secondary glaucoma, cataracts, hyphemia, and uveitis. Early withdrawal of the drug is the only effective therapy.

719 Park Avenue

Rushin' Roulette

From time to time newspapers carry accounts of one of the most reckless and inexplicable acts of civilized man — the game of Russian Roulette. What a fool, we think of the victim, to bet his life on the chance of spinning one of the five empty chambers against one that contains a live cartridge.

Yet every year Americans by the millions, in a senseless game of Rushin' Roulette on the highway, bet their lives equally recklessly that the spinning wheels of their automobiles won't result in death or injury. The comparison is apt, for the overwhelming majority of casualties, like those from Russian Roulette, are the result of heedlessness or deliberate chance-taking.

More people were killed on our streets and highways in 1962 than in any previous year—40,500—thus "breaking a record" (if that is the appropriate phrase) that had stood since 1941.

Rushing down our highways and byways, the spinning wheels and steel bodies of our automobiles also maimed more persons than ever before. By the end of the year, 3,345,000 persons had been injured.

Yet this senseless destruction of human life and limb need not go on.

The principal cause of accidents is the person most able to avoid them, the man behind the wheel, the man who holds the gun.

Not safety belts—
Not better superhighways—
Not mechanical improvements in auto design—
Not padded instrument panels nor deep dish steering wheels—
Not stiffer license requirements—
Not any of these can put an end to this wild national game of roulette on the road.

All these things help, but the finger of statistics is not pointed at the engineers and designers; its pointed at you, the driver.

You, who drove your mechanically perfect car in good weather on a straight road—too fast.

You, who passed on hills and curves.

You, who drove after drinking.

You, who violated the rules of the road and failed to yield the right of way.

You, who handed over to your teen-aged sons and daughters the controls of a hurtling ton of steel propelled by the power of 300 horses without giving them a realistic understanding of the forces they were attempting to handle.

You, who drove too long without rest, who pushed on home late at night after a long, fatiguing week-end of play.

Yes, Mr. Driver, 87 per cent of accidents causing highway death and injury, the statistics coldly say, *were the direct result* of violations of the rules of the road, excessive speed, driving on the wrong side of the road, failing to yield the right of way and reckless driving.

Like the fool who plays Russian Roulette with a six-shooter, the man behind the wheel needs nothing more than his own will power to avoid the consequences of his action. For the best automobile and highway design, like the best of the gunmaker's art, is of no avail if the weapon is wielded by a careless person, and if the obvious rules of common sense are ignored.

Occasionally the bullet in the six-shooter is badly aimed, and the player of the game survives his folly—maimed but not killed. In such cases, he rarely tries to play the game again.

Can it be, Mr. Driver, that you will abandon this monstrous game of carelessness and chance-taking in 1963? Or will you, like the idiot vainly spinning the gun chamber, point an automotive bullet at your own head and pull the trigger with your own hands?

—Rushin' Roulette—the 1963 Safety Booklet of the Travelers Insurance Company, Hartford, Connecticut.

William Rubin, M.D.

New Brunswick

Retino-Cerebral Re-Education Through Pleoptics*

A Pilot Study with a New Dimension in Therapy

Here is an account of an exciting project in treating strabismic amblyopia with pleoptic technics at a special summer camp. Six of the 15 children developed binocular vision and third degree fusion by the end of the project.

The treatment of amblyopia has reached a new and exciting level of success. More and more favorable reports are emerging from those European ophthalmic centers where both the sensory and motor aspects of ocular motility are dealt with intensively.

Wald and Burian[1] have shown that the threshold of the amblyopic eye was normal foveally and peripherally in light and dark adaptation. Van Noorden and Burian[2] have demonstrated how remarkably good was the vision in amblyopic eyes in reduced illumination. It is upon this evidence as well as upon that obtained from our own experiences that we are forced to assume that the amblyopic eye may have no significant pathologic defect in structure or function. Bangerter[3] has displayed great genius in devising instrumentation for effective foveal stimulation. Cüppers[4] continued this fine work by applying novel uses of the negative after-image to correct the visual directions of corresponding retinal points disturbed by eccentric fixation. These technics have met with criticism in this country primarily because of the prolonged hospitalization. School authorities find a disruption of school routine unacceptable and parents consider the cost of a prolonged hospital stay prohibitive.

With this in mind, I conceived of furnishing pleoptic training methods during the summer to amblyopic children in a camp-like environment. A one-hundred acre farm in a secluded mountain area (two hours from metropolitan centers) was selected. On this farm were two large barns, a workshed, and a large dwelling with many small rooms ideal for children's bunk beds. Assorted furnishings, kitchen equipment, and recreational facilities were installed to accommodate about fifteen children, their five counsellors, and four orthoptic technicians. It was felt that if each child were to have two one-hour periods of training a day, at least four technicians would be necessary.

1. Wald, G. and Burian, H.: American Journal of Ophthalmology, 27:950 (1944).

2. van Noorden, G. and Burian, H.: Archives of Ophthalmology, 61:533 (1959). Also, same authors: American Journal of Ophthalmology, 46:68 (1958).

3. Bangerter, A.: *Concilium Ophthalmologicum Belgica*, 18:105 (1958).

4. Cüppers, C.: *Klinische Monatsblatter for Augenheilkunde*, 129:5:579 (1956).

*Presented at the Annual Meeting of The Medical Society of New Jersey (Section on Ophthalmology) in Atlantic City, May 16, 1962.

Observations of foreign workers and personal experiences at our own center have led me to believe that if less than two hours were devoted to therapy, effective daily gains would be less likely to occur. On the other hand, if this period were exceeded, the child might become fatigued or bored and lose his enthusiasm for treatment.

For this preliminary study no effort was made to be selective. Only if the amblyopia could be ascribed, unequivocally, to pathologic changes in the macula or other structures of the eye was the child rejected. Such unfavorable cases therefore were included as marked anisometropia, nystagmus and marked eccentricity of fixation.

Although an understanding was had with all parents that a child would be allowed to continue during the second month only if recognizable progress was made during the first month of summer camp, no child actually was deterred from entering the second period of treatment.

The preliminary investigation of each amblyopic child consisted of visual acuity determination with and without correction for individual "E's" and "E's" in a row on a Snellen chart. Near vision, where obtainable, was also taken. The type of fixation ascertained by visuscope or ophthalmoscope with a suitable graticule was then noted as steady, unsteady centric, parafoveal, macular, paramacular or eccentric. Where the angle of squint was so large as to make treatment with the pleoptophor difficult, surgery was advised prior to treatment. Several children had their muscle surgery performed long before these newer methods were available.

Essentially, a combination of Bangerter's foveal stimulation technic and Cüppers afterimage methods were used. For these, the pleoptophor, localizer, coordinator, space coordinator, Oculus synoptophore, euthyscope, and separation trainer were found to be basic instruments, fulfilling an important need.

Since the children varied in age from seven to seventeen, care was needed in organizing recreational activities to satisfy both the junior and senior boys and girls. Thought was given to each child's talents and qualifications in arranging their activities. Treatment schedules were adhered to closely. Arts and crafts were adapted to allow ready transition from these activities to the serious matter of retinocerebral re-education in the treatment rooms. All of the children were hampered by the lack of binocularity and fusion, since the pleoptic method is based on occlusion of the poor eye. Yet it is easy to understand why these amblyopic children were able to play a good game of table tennis, baseball, or volley ball, paint landscapes, carve a head, or do a square dance. The acceptance of occlusion became almost a ritual. If a patch slipped off, a child would voluntarily seek out someone to replace it. In the meantime the child would contract his orbicularis oculi firmly to avoid the light. The important psychologic factor of "belonging" to a group of children having a similar defect and identical aim allowed the child to consider occlusion almost a normal way of life. Indeed, so desirable was this patching that several normal children, whose mothers held positions on the staff, pleaded to have their eyes patched, finding conformity a greater need than binocularity.

As treatment progressed to the point where the eccentric eye became centric the patch was switched to the good eye. At this stage visual acuity also improved, permitting the child to participate in all camp activities with considerable efficiency and enthusiasm. Instead of feeling frustrated when the change in occlusion was made to the good eye, the child was encouraged because he could proceed to this step before the other children. And he was cheered by the others for having made this progress.

Arts and crafts were geared to the therapeutic requirements. Knitting and embroidering (joined in by both boys and girls) were practiced with the smallest of needles and finest of yarns and threads. Alphabet noodles were used in word building games and jewelry making. Puppetry and costuming were designed to offer relaxation and diversion. The bigger boys were allowed to construct things with simple carpenter's tools. Organized

sports were planned to stimulate group interest and camaraderie. Waterfront sports, such as boating and swimming, were available on the premises and therefore were scheduled daily between the treatment periods.

The important role of good humored rivalry, each child seeking to make greater progress than the next, cannot be overestimated. Those with lower visual acuity were urged to participate in sports requiring less precise vision. It was amazing to see how well some of the children using the poor eye were able to perform where better vision should have been required.

The progress of each child was discussed at weekly staff conferences and the type of treatment to be pursued outlined for the coming week. Where the child was unable to obtain a suitable negative after-image (because of deep-seated suppression or because of the immaturity of the child) direct foveal stimulation with dazzling of the peripheral area was employed. This was followed according to the Bangerter method [3] with the localizer, separation trainer and assorted "E's" for improvement of visual acuity. When a good foveal negative after-image was obtained by means of the pleoptophor or euthyscope, intensive application soon resulted in marked improvement in visual acuity for smaller letters as well as in foveal capacity to localize objects in space. Repetition of these acts, coordinating hand, eye and brain was the basis for retino-cerebral re-education and proper space orientation.

Haidinger Brushes, a check on foveal fixation were used in the coordinator, space coordinator and Oculus synoptophore for monocular and binocular training. Our results for the two months showed that 6, or 40 per cent of all cases, developed binocular vision and third degree fusion. The remaining nine children improved in visual acuity sufficiently to warrant further training with an aim toward development of fusion.

Results of this pilot study of the treatment of amblyopia by pleoptics under the most favorable of circumstances are shown in the tables. Analysis of the data indicates that therapy is most effective where the type of fixation is parafoveal and the visual acuity better than 20/200. However, centric fixation, 20/30 visual acuity and third degree fusion are obtainable even where fixation before treatment is peripheral and the visual acuity less than 20/200 in the amblyopic eye.

From Table 1 it can be seen that in the ages seven to 17 no difference was noticed in the result of treatment. The advantages of treating the younger child are well compensated for by the greater concentration and attention span of the older child.

CONCLUSION

RETINO-CEREBRAL re-education can be an effective approach to the problem of amblyopia. However, it must be concluded that where the amblyopia is marked and the strabismus noticed before the first year, a period longer than two months will be necessary to establish such long-neglected functions as normal foveal binocular single vision and fusion. The importance of setting and the implications of group therapy were explored at a center where intensive treatment was furnished daily.

SUMMARY

FIFTEEN non-selected children ranging from seven to 17 years of age with strabismic amblyopia were treated at summer camp with pleoptic technics. Sixty-six per cent of the group acquired better than 20/40 vision; 60 per cent developed centric fixation; 40 per cent developed third degree fusion and stereopsis.

184 Livingston Avenue

TABLE 1.

Before Treatment Visual Acuity Amblyopic Eye	Fixation	Child's Age	After Treatment Visual Acuity Amblyopic Eye	Fixation
20/50*	p.f.	7½	20/30*	u.c.
20/200*	p.m.	8	20/100*	u.p.m.
20/100	p.m.	8½	20/60	u.p.m.
20/50	p.f.	9	20/15	centric
20/50	p.f.	10	20/20	centric
20/100	p.f.	11	20/30	centric
20/100	u.p.f.	12	20/50	u. centric
20/200	periph.	12	20/100	p.m.
20/800	u. periph.	12	20/60	centric
20/100*	periph.	12	20/20*	u. centric
20/150	p.m.	13	20/20	u. centric
20/200	p.m.	13	20/30	centric
20/600	u. periph.	15	20/30	u. centric
20/400	u. periph.	16	20/100	u.p.m.
20/100	u.p.m.	17	20/40	u. centric

*s.c.—All the others were c.c.
p.f.—parafoveal
p.m.—paramacular
u—unsteady

TABLE 2.

CHANGES OF FIXATION AS A RESULT OF TREATMENT

	Parafoveal	Paramacular	Peripheral	Total
Number	3	8	4	15
No. of Cases with centric fixation after therapy	3	4	2	9
Proportion	100%	50%	50%	60%

TABLE 3.

RESULTS RELATED TO INITIAL VISUAL ACUITY

Number of Cases	Visual Acuity	With 3d Degree Fusion Number	With 3d Degree Fusion Per Cent	With 20/30 Acuity or Better Number	With 20/30 Acuity or Better Per Cent
3	20/40 to 20/80	3	100%	3	100%
8	20/80 to 20/200	2	25%	5	65%
4	20/300 to 20/800	2	50%	2**	25%**
15		7	48%	10	67%

**One with 20/40 visual acuity

Adrian M. Sabety, M.D.

John E. Masterson, M.D.

Hugo Gelman, M.D.†

Franklyn P. Gerard, M.D.

East Orange

Atrial Septal Defect*

Atrial septal defects can be corrected surgically if attempted before pulmonary hypertension develops.

Atrial septal defect is the most successfully managed intracardiac defect to which surgical correction has been applied. This abnormality counts for about 15 to 20 per cent of all congeni al heart diseases [1] with a sex distribution of about two females to one male. During the past few years, our experience with correction of this defect has permitted the evolution of a number of refinements in diagnosis and surgical treatment contributing to ease of management. The refinements have been reflected in falling mortality and morbidity of the surgical cure of this defect to *nil* in cases not accompanied with pulmonary hypertension. The aim of the present report is to bring out those factors in refinements in pre- and postoperative management which have influenced most dramatically such a drop in mortality and morbidity. There is a serious risk and there are relatively poor results of surgical correction of this defect in patients who present signs and symptoms of advanced pulmonary hypertension. This contrasts with the smooth postoperative course and low mortality and morbidity in cases of atrial septal defect, not complicated by the pulmonary hypertension. This fact strongly indicates that these defects should be closed when they are recognized to be present and hemodynamically significant. There is nothing to be gained by procrastinating and none of these people will improve with time.

PATHOLOGIC TYPE

Detailed discussion of the anatomic pathology of atrial septal defect may be found in textbooks. From a surgical point of view the following lesions are encountered and classified:

(1) *Septum secundum* or *central defects.* These are true foramen ovale defects and may present themselves in a variety of forms and shape including fenestrations.

(2) *Superior marginal defects* (sinus venosus).

(3) *Inferior defects,* which include ostium primum defects. These rare abnormalities are situated in the lower portion of the septum. There is no inferior margin detectable above the upper edge of the ventricular septum, but also, there is no defect or cleft in either of the mitral or the tricuspid valve. (Case 8).

(4) *Atrioventriculare communis.* This group truly is not an atrial septal defect but a complete absence of septum between the auricle and ventricle.

*From the Ewing Heart Unit, Hospital Center at Orange, N. J. and the Cardiac Clinic, Mountainside Hospital, Montclair, N. J. This study was supported in part through a grant in aid by the Department of Health, State of New Jersey, No. D66, and the Victoria Foundation.

†Fellow in Cardiology.

1. Wood, P.: *Diseases of the Heart and Circulation.* Philadelphia, 1961, Lippincott. Ed. 2, Page 360.

Of all the varieties mentioned above, the most common abnormality of the atrial septal defect is that of the septum secundum, which may or may not be in combination with other types of abnormalities, such as mongolism or coarctation of the aorta. Of great surgical importance, however, is the presence (or absence) of abnormal pulmonary vein drainage. In almost all instances of atrial septal defect the right pulmonary veins are entering into the right atrium, or enter so close to the margin of the defect that the veins may be considered actually draining into the right atrium. The correction of the defect places the veins in their normal left atrial position.

NATURAL HISTORY

During the intra-uterine life there is no ill effect from atrial septal defect, since it is a physiologic pathway of embryonic circulation. The left and the right ventricles are of the same size, strength, and pressure. The systemic and pulmonary vascular resistances are equal. Soon after birth, when the resistance in the peripheral circulation has increased (and consequently the pressure in the left side of the heart has risen) the left-to-right shunt through the defect develops. These changes occur relatively slowly so that the heart and the circulatory system are able to adjust to this abnormal hemodynamic condition. This is true in the first years of life when the patient may tolerate enormous shunts without serious trouble. However, as the volume of this shunt gradually becomes larger, it results in pulmonary flow that may be two to three times the systemic flow. To accommodate this volume, the pulmonary vessels dilate and the resistance falls. The right ventricle becomes overloaded, particularly during the diastolic phase. The dilatation is in response to the demand and the electrocardiogram reflects it by showing a delay in conduction. The prolonged exposure to excessive flow is also occasionally associated with morphologic changes in pulmonary vessels, eventually resulting in pulmonary hypertension. (Cases 1 and 4.) The genesis of the pulmonary hypertension is a question of major importance in atrial septal defect, since major elevation of pulmonary artery pressure makes a surgical repair impossible. The pulmonary vascular bed ordinarly can accept and accommodate increases in blood flow and, as a rule, in atrial septal defect in spite of large blood flow, the pulmonary arterial pressure is only slightly elevated. Whether or not the long-standing left-to-right shunt may predispose to thickening of the wall of the vascular system with subsequent pulmonary hypertension, is suggestive. Clinical experience, as well as the experimental evidence, suggests that such a situation does occur (Case 3). On the other hand, since pulmonary hypertension is rarely seen in conjunction with atrial septal defect, so it may be that other factors are responsible for the appearance of the complication beside the high flow. For instance, the size of the defect does appear to be related to the appearance of pulmonary hypertension, as demonstrated by Jones.[2] Once the pulmonary vascular resistance has increased to a point where it approaches and exceeds the systemic pressure, reversal of flow occurs and the patient becomes cyanotic. In this group of patients surgical correction carries high mortality, morbidity, and questionable improvement. (Cases 1 and 4).

SIGNS AND SYMPTOMS

The diagnosis of atrial septal defect may be established by a clinical evaluation alone in about 90 per cent of the cases, even before onset of subjective complaints. Children frequently show retarded growth and are underweight. This is attributed to the diminution of the blood flow through the aorta. These patients also experience increasing fatiguability and exertional dyspnea. In children this is not very striking, because of the remarkable tolerance to a cardio-respiratory handicap. Only after the correction of the abnormality is one impressed by the dramatic improvement in the exercise capacity of the child (Case 2). Frequently, there is a history of repeated upper respiratory infection, which may well be sec-

2. Liddle, H., Meye, B. and Jones, J.: Journal of Thoracic and Cardiovascular Surgery, 39:35 (1960).

ondary to the tremendous pulmonary congestion. Usually a systolic murmur of "ejection" type is heard over the second left sternal border. This is caused by the passage of a large volume of blood through the pulmonary valve. Splitting of the first heart sound is frequently heard. This is because of the unusually delayed closure of the tricuspid valve followed by delayed opening of the pulmonary valve. The increased stroke volume of the right ventricle causes the second sound to be widely split and the pulmonic component accentuated. At chest x-ray, one usually finds cardiomegaly due mainly to enlargement of the right atrium and right ventricle. The pulmonary artery is dilated and the pulmonary vasculatures show congestion due to the increased blood flow.

DIAGNOSIS

WHENEVER a large atrial septal defect is suspected, cardiac catheterization should be performed to obtain precise figures as to the magnitude of the shunt, so that operative closure of the defect can be accomplished before serious complications develop. Useful information is derived from the calculation of systemic blood flow, pulmonary blood flow, and shunt blood flow. Although the figures are probably only rough estimates, they are accurate enough to give valuable clinical information about the volume of the shunting and the existence of pulmonary vascular obstruction. Most individuals with a large defect will show some elevation of the pulmonary arterial pressure, despite normal pulmonary vessels, because such a large volume of blood is being forced through the normal vascular bed (Case 3). These patients must be differentiated from the rare individuals who have actual anatomic constriction of the pulmonary arterioles. The differentiation can be made only by the calculation of the pulmonary blood flow and calculation of the ratio of the blood pressure to the blood flow in the lungs. It is useful to correlate the volume of shunting, as calculated by cardiac catheterization, with x-ray evidence of pulmonary congestion and cardiac enlargement. When the volume of shunting is large, but the lungs are not seriously congested and the heart not greatly dilated, the patient tolerates the operation well. In contrast, individuals with serious pulmonary engorgement and cardiac dilatation, but with the shunt flow of a smaller magnitude, tolerate the operation poorly and develop cardiac difficulties following repair (Case 4). In the presence of pulmonary vascular obstruction, the volume of the shunt is reduced; however, it remains predominantly a left-to-right shunt. Even with a reduction of shunt, right heart work actually increases as pulmonary resistance becomes more pronounced. Closure of an atrial septal defect, complicated by severe pulmonary vascular resistance, is often associated with acute right ventricular dilatation and fibrillation (Case 1). Selection of patients with severe pulmonary hypertension, who will tolerate closure of the defect, is difficult and evaluation of pulmonary arterial pressure alone is not sufficient criteria. It is also interesting to note that the low degree of left-to-right flow does not necessarily mean a benign progress of the disease.

TREATMENT

IN THE last few years a variety of surgical technics have been devised for closure of the atrial defect. These procedures ranged from some ingenious methods of closing the defect by external means to the approach devised by Gross,[3] where a plastic well was sewn over the right atrium; the latter was then opened, and the sutures placed to close the defect by palpatory guidance through the atrial well. Many clinically adequate closures have been obtained by these methods but, at best, they were not anatomically as satisfactory as they would have been under direct vision. Recently, with the improvement in the application of cardiopulmonary bypass, nearly all atrial septal defects can be closed completely and adequately. The refinements in technic of cardiopulmonary bypass as well as improved surgical methods of closure of the defect have rendered this procedure reasonably safe and with a mortality and morbidity comparable to that of any other major operative procedure.

3. Gross, R. and others: *Surgery, Gynecology and Obstetrics*, 96:1 (1953).

The technic used at the Ewing Heart Unit of the Hospital Center at Orange, which has given us gratifying results, is as follows:

The patient is placed on his back on the operating room table and rotated slightly to the left. After anesthesia and intubation has been accomplished, venous and arterial cut-downs are done for direct measurement of the respective blood pressures. The heart is approached through a right anterior thoracotomy at the level of the third interspace and occasionally by incision of one or two costal cartilages. The left femoral artery is exposed through a longitudinal incision and dissected free for about two to three centimeters in length. The pericardium is opened in the usual fashion and the heart exposed. The superior and inferior vena cava are cannulated as well as the left femoral artery. The patient is connected to the cardiopulmonary bypass, which is our modification of a Kay-Cross oxygenator and the patient is placed on partial bypass. Once the pressures are stabilized, the bypass is made total by constriction of the superior and inferior vena cava over the cannule and the right atrium is opened wide. At this time the blood in the right atrium is aspirated and the defect exposed. We are very careful not to aspirate the blood from the left atrium in order to prevent the possibility of air emboli. Occasionally, the action of the left ventricle and the mitral valve is so effective that air is nearly sucked into the left side of the heart through the open defect. For this reason we allow some blood to stagnate over the defect during the closure. The edges of the defect are picked up and the defect is closed with continuous atraumatic silk sutures.

In our cases, only on a few occasions was it necessary to use a patch to bridge the atrial septal defect. Usually, no prosthesis seems to be necessary. Once the defect is closed, the tourniquets around the superior and inferior vena cava are loosened and the right atrium is flooded with blood and the air forced out. The incision is closed with continuous atraumatic fine silk sutures. The patient is taken off the pump oxygenator and the cannulae are removed. The femoral arteriotomy is closed with fine atraumatic arterial sutures. The pericardium is closed loosely. Tubes are inserted in the pleural cavity and connected to a waterseal system. The chest is closed in layers in the usual fashion. Usually, the arterial and venous pressure lines are kept open until the patient has completely recovered and the vital signs are normal. We have found that by continuous monitoring of the arterial and venous pressures during the early postoperative period we are in a better position to judge the blood volume of the patient than by any other means.

SUMMARY AND CONCLUSION

1. Eight consecutive cases of surgically corrected atrial septal defects are reported. Of these, five showed normal or slightly elevated pulmonary tension, while three suffered from a very high pulmonary pressure. There was no operative mortality in the group without pulmonary hypertension. They all are living and well with a perfectly normal heart. The three with high pulmonary pressure were of a relatively older group. Only one survived the operation and her heart function returned to normal. Two died of heart failure on the second and third postoperative day. Postmortem examination in these two cases and the lung biopsy obtained at operation on the surviving case showed arteriosclerosis of the pulmonary artery system.

2. This survey dramatically demonstrates the value of early recognition of this abnormality and attempt at its correction. With the refinements in surgical technic, the mortality and morbidity are extremely low and comparable to any other major operative procedure, provided irreversible complications such as pulmonary hypertension, are not present. Once the pulmonary hypertension is established, the selection for operation should be based on the evaluation of the pressure/flow relationship. This may give an idea whether the pulmonary hypertension is irreversible. A plea is made to detect and correct this abnormality *before* these complications present themselves. There is nothing to be gained by procrastinating and none of these people will improve with time.

Addendum: Since this manuscript was submitted, four additional consecutive successful cases have been completed, bringing total of ten cases of Primary closure of atrial septal defect by open heart method, with no operative mortality.

144 South Harrison Street

Details of the eight cases, omitted from this report, will be found in the authors' reprints.

Bernard Robins, M.D.

Westfield

Zinc Insulin Combinations

An Alternative to Multiple Dosage Insulin Therapy

Multiple daily insulin injections constitute an onerous burden for the diabetic. Combinations of lente insulin may lead to control with only one injection a day.

Multiple daily dosages of insulin (usually of intermediate duration of action) have been invaluable in the management of a small group of growth onset or unstable diabetics.[1] Isophane (N.P.H.) insulin given twice daily, will regulate and smooth out the blood sugar levels of these patients especially if supplemented by regular insulin in small doses when indicated. To reduce the burden of multiple daily doses, many have tried to control such patients with one daily injection of intermediate or long-acting insulin. All too frequently, this has led to regretable hypoglycemia.

The inconvenience of multiple daily injections is a serious problem to many diabetics. One daily injection which could reproduce the actions of multiple injections is most desirable. This could be realized if short, intermediate, and long-acting insulins were completely miscible in a bottle or syringe, and yet maintained their own potency, and their own time-action curves. The lente triad* of insulins meets these qualifications[2,3] and can offer once daily administration to many, if not all, of these patients.

The lente insulins have been known[4] since their preparation in 1952. With an acetate buffer it is possible to combine small concentrations of zinc with regular insulin. The resultant suspension of insulin and zinc then has properties dependant upon the pH of the solution. Appropriately controlling the pH results in the formation of a crystalline fraction or an amorphous fraction. The crystalline fraction has an insulin action similar in onset, peak and duration of action to protamine zinc insulin and is called *ultralente*. The amorphous fraction has an action somewhat between regular and N.P.H. insulin and is called *semilente*.* The amorphous semilente and the crystalline ultralente can be combined together in any proportion. A mixture of 70 per cent ultralente and 30 per cent semilente has an action almost identical to N.P.H., and is commercially available[5] as *lente insulin*. Thus, three insulins are now available which can be mixed with each other in any proportion, each maintaining its own characteristic time-action curve. These are: *semilente*, a short-acting insulin; *lente*, an intermediate-acting insulin; and *ultralente*, a long-acting insulin.*

*Lente insulin is so-called because it is slow acting. The word *lente* is not a brand name; it comes from the Latin *lentis*, meaning "slow" (in the sense of mild or lazy). Grollman in his book *Pharmacology and Therapeutics* (Lea and Febiger 1962), defines insulin as a mixture of minute particles of crystalline zinc and amorphous insulin. The "triad" of lente insulins is listed by "an admixture of lente, semilente and ultralente zinc insulins." (In the 1959 Saunders edition of the Cecil-Loeb *Textbook of Medicine*.)

CASE REPORT

A 46-year old man developed diabetes ten years ago. At that time he weighed 160 pounds. He went into ketoacidotic coma before diagnosis or treatment. He had been on insulin constantly since that time. He came under my care in July 1961. At that time he was taking 40 units N.P.H. insulin in the morning. His diet was A.D.A. approximately 2000 calories. The complaints at that time were polyuria, polydypsia and marked weakness. His weight was 139. Blood sugar was 310 (Folin-Wu). He had 4-plus glycosuria and 1-plus acetonuria. Examination did not reveal any complicating factors.

Attempts to control the patient with increasing amounts of N.P.H. insulin caused mid-afternoon hypoglycemia despite extra feedings. Accordingly, he was placed on N.P.H. before breakfast and again before supper. However, forenoon glycosuria could not be eliminated without small amounts of regular insulin added in the morning.

Excellent control was achieved by giving 54 units N.P.H. and eight units regular insulin in the morning and 17 units of N.P.H. before supper. His weight then climbed to 162 and his strength and feeling of well-being returned. Urinary spillage was virtually negative and shocks did not occur. On this regimen, fasting blood sugar varied between 95 and 132; blood and postprandial blood sugars varied between 160 and 185.

Because of the necessity for multiple injections it was thought worthwhile to attempt control with the lente insulins. He was placed on 52 units lente and eight units ultralente mixed in the same syringe and given before breakfast. His weight and strength have remained the same and chemical determinations of blood and urine have been as above.

This patient was originally seen while out of control. Since he was "perfectionistic" in his attitude towards the disease it was clear that dietary management had been carefully adhered to. Actually, he had been underinsulinized because of mid-afternoon hypoglycemia reactions. Multiple doses of insulin easily corrected this state. The switch to the lente insulins allowed the patient good control on one insulin injection daily.

Any one variety of lente insulin, by itself, offers little advantage over the use of other insulins. In fact semilente has a time-action curve too short to be of use except in a few cases. Ultralente, on the other hand, is similar to protamine-zinc insulin and is limited by the frequent occurrence of nocturnal hypoglycemia. However, the absence of protamine from the lente insulin saves them from the theoretical disadvantage of being heparin antagonists, since protamine is known to neutralize the heparin effect on the clotting mechanism. The long range effect of this on blood lipids is at present unknown. Indeed, the absence of any protein (except for that inherent in insulin) makes the lente insulins less antigenic, but not absolutely so.[7]

IN THE area of combinations the lente triad offers a distinct advantage. A wide variety of time-action curves are available, and these can be adjusted in any suitable proportion. Patients requiring multiple insulin administration during a 24-hour period usually have varying degrees of insulin response and requirements during the day. Early hour needs may be great and later hour needs minimal. If enough of a prolonged action or intermediate action insulin is given fully to utilize these peak glucose loads, then enough will remain to cause dangerous hypoglycemia at hours at which the requirements have sharply diminished. This is especially true if during the day, there are two peaks of insulin need separated by a time of minimal need. Multiple injections of insulin during a day (each injection preceding a peak load) will control such a situation. By using the lente triad. the action of multiple injections can be duplicated by combining into one injection, the type of insulin and amount of insulin which best mimics the action of each of the individual injections used before. Suppose a patient is getting two daily injections of N.P.H. before breakfast and before supper; he will often do well by using lente as a substitute for the morning N.P.H. and ultralente as a substitute for the evening dose. The lente and ultralente can be mixed together and given in one injection in the morning. Patients with daytime hyperglycemia and nocturnal hypoglycemia do best on semilente and lente in combination.

Those with nocturnal and morning hyperglycemia require ultralente and lente. Frequent observation of blood and urine will lead to corrective adjustments.

SUMMARY

If a diabetic needs many daily injections of insulin, it is often possible to achieve the desired flexibility and time-action curves, by mixing in one bottle or one syringe a combination of the three varieties of *lente* insulin. An illustrative case is cited.

1009 Tice Place

BIBLIOGRAPHY

1. Colwell, A. R.: *Diabetes,* edited by R. H. Williams. Hoeber, New York.
2. Haunz, E. A.: Journal of the American Medical Association, 159:1611 (June 1955).
3. Whitehouse, F. W., *et al.*: Annals of Internal Medicine, 55:894 (August 1961).
4. Hallas-Moller, K., *et al.*: Journal of the American Medical Association, 150:1667 (December 1952).
5. Murray, I.: The Practioner, 175:502 (May 1955).
6. Marble, A.: Medical Clinics of North America, March 1957, page 1.
7. Cont, Constance, G. R.: Northwest Medicine, 55:1023 (November 1957).
8. Izzo, J. L.: American Journal of Medicine, 20:554 (April 1956).

Cost of Drugs and Value Received

I recently had a patient who had pneumonia. After five days of treatment he felt so much better that he wanted to return to work. He then began to complain of the high cost of the drugs he had to take. I said to him: "Next time you get ill, remind me not to prescribe these drugs, but to treat you in the manner we did 30 years ago—mustard plaster, brandy, and the like, and waiting for the 'crisis' to break about the ninth day, with a 50-50 chance of recovery. If you 'made it' it would be about two months before you would be ready to return to work—provided you have not collected pus which may require rib-resection for drainage." My patient remarked he had not thought of it that way and now realized the drug bill was very little to pay for value received.Walter W. Hughes, M.D., in *New Medical Materia,* March 1962.

Ob-Gyn Seminar in New Brunswick

Announcement is made of a seminar on obstetrics-gynecology to be held at St. Peter's Hospital, New Brunswick, on Wednesday, October 30. The morning session, which begins at 10:00 a.m., is devoted to problems of pregnancy. The afternoon session, starting at 1:30 p.m., includes a paper on the complications of hysterectomy and a panel on the ovary.

All New Jersey physicians are invited. For a detailed program, reservations, and luncheon tickets, write to: Department of Medical Education, St. Peter's Hospital, New Brunswick.

Henry Z. Goldstein, M.D.

Newark

Hearing Problems of the School Child

Poor scholars sometimes turn out to be hard-of-hearing children of good basic intelligence. The pre-school period is the time to determine hearing levels.

Education depends upon communication between parent and child, teacher and child, and even between child and child. Communication depends upon vision, hearing and speech. An impairment of any one of these functions will interfere with education in direct proportion to the severity of the defect. In this paper, I am primarily concerned with that function which is constituted by hearing.

In the Newark Education Department, by a *hearing defect* is meant those children who have losses of over 15 decibels in any one or more frequencies on two separate pure tone audiometric examinations. Of course, this defect may or may not be incapacitating.

A deaf child is one in whom the sense of hearing is non-functional for the ordinary purposes of life as promulgated by Silverman's Committee on Nomenclature of the Conference of Executives of American Schools for the Deaf.

By a *hard of hearing child* is meant one in whom the sense of hearing, although not normal, is functional with or without a hearing aid.

A loss, in my experience, of about 25 decibels in the frequencies 500, 1000 and 2000 have proved a definite handicap.

For practical educational purposes, we do not concern ourselves too much about the difference between congenital and acquired deafness. The severity of the deafness is the important factor. The presence or absence of speech is not a determining factor in the problem of placement.

The problem of hearing difficulties in the school age child is an ever growing one. A "hard of hearing" school child program is best integrated when correlated with a school program along the same lines. This growing problem is more than ever brought to a focus by the increasingly greater number of adult population who are being recognized as partly or even completely deaf. Actuaries have estimated that by 1980 more than half of our population will be over 45 years of age and hence, there will be an increased number of hearing loss in the aged whose onset of deafness was during school age. Had this been recognized and adequate treatment been given earlier, the permanent difficulty in adulthood might have been avoided. Some three to four per cent of the entire school population has some hearing defect. In this count 60,000 school children are totally deaf; 3,000,000 are hard of hearing; and 5,000,000 have some speech defect. These figures lend weight to the importance of intensive campaigns to reduce this and a start should be made both in the pre-school and school child.

Recognition

The first problem encountered is that of the recognition of the hard of hearing school child. Here, children fall into two large main groups. In the *first group,* the child is brought to the school by the parent for registration. The parent already knows that the child has some handicapping hearing difficulty because of speech delay, lack of response or inatten-

tion. The child has been examined by an otolaryngologist or at a neighboring hearing center. The parent comes to the school well fortified with diagnoses, audiometric readings and letters of recommendation. Such a child is immediately sent to the school audiology department for placement. An audiologic survey may be done if records indicate that the child has not been examined for some time. Every effort is made to cooperate with outside agencies and effort is made to follow the recommendations of the hearing center or private otologist as far as possible, within the structure of the school system. This group presents little problem to the school system because both the parent and the child have been conditioned to examinations and the parent has come to understand the needs, present and future, of the child. The parent has already been educated to cooperate to his fullest extent. All necessary medical and surgical procedures have been followed out even before the child is registered at school.

The *second group* consists of children who have already been placed in school and children, registering for the first time, in whom the parent is not aware of a defect. Recognition in this group very often starts with the school nurse, school physician and school teacher, because of poor work, inattention, poor speech, poor play habits and conflicts. Attention is then focused upon discovering the cause.

In the Newark School System, routine screening by pure tone audiometry in the third, fifth and sixth grades reveals many children with hearing defects.

DISPOSITION

As soon as a defect is recognized, the problem is discussed with the parent who is told that the child be thoroughly examined, both systemically and audiologically. The father has the privilege of having this performed by a private hearing center or otologist; or (if he so desires, or is indigent) he may be referred to the school otology department. However, wherever the child is referred, he must receive a thorough study, including a pediatric examination, a psychologic appraisal and a meticulous audiologic evaluation with proper equipment.

The problem then becomes twofold. First is the responsibility of the private otologist, hearing center or school otologist to make a complete evaluation of the audiologic status of the child. This covers a complete and thorough history, including pre-natal, natal, birth injuries, post-natal, family history and a history of all illnesses that have occurred in the child since birth. It then includes a thorough audiologic examination, including examination of the nasopharynx, ears, eustachian tube, throat and nose. This is to be followed by a complete audiologic estimation so that an accurate diagnosis and an accurate (as far as possible) estimation of residual hearing be made. All this is to be done in conjunction with a careful pediatric and psychologic evaluation. A speech survey is also made, if indicated. I do not wish to enter, at this time, upon a discussion of the equipment needed or the technic used in testing these school children, save for a few highlights of my own experience. I would like to quote Dr. Guild, who says, "the information obtained from elaborate tests or batteries of tests is primarily of research interest. It would take ten hours per patient to perform all hearing tests regarded by one or another investigator as of interest or value."

Above the age of six we have no great problem in either pure tone or speech audiometry, save in those who have not developed patterns of speech understanding or in those who are emotional or psychologic problems. Difficulties also develop if there is definite cerebral damage or if the child is aphasic. Our greatest problem lies between the ages of early school attendance, that is between four and a half and six years. The difficulty lies not only in estimating the residual hearing in these children, but is also partly due to the lack of standardization as to the methods of testing these children. One well-known otologist insists that speech audiometry is the best approach, associated with some conditioning method. Another equally famous otologist insists that pure tone audiometry is excellent, while speech audiome-

try is valueless. There is even a difference in the recommendation as to the type of speech audiometry. Some recommend recorded voice, some recommend live voice, some numbers, some words and others, sentences. There is no nationwide standardization of these tests and recommendation of specific tests after nationwide evaluation. Until that standardization occurs, it behooves each otologist to use those means which give him, in his experience, the best results in testing the youngest school child.

These children come in very often in terror, grasping their parents hands in despair. Often many visits must be made before any degree of trust or confidence can be obtained. Anything that smacks of a doctor, nurse, or uniforms associated with them, may create terror in these young school children. At the age of 4½ or 5 the span of interest is small. Tests must be limited to short periods. Often, it is helpful to use the parent as the testing mechanism by quiet or even louder conversational voice. This aids a great deal, with myself as a mere bystander. An attempt to use pure tone audiometry through ear phones has rarely worked for me in this group. Of course, there are exceptional cases where nearly all kinds of tests may be performed, but we are dealing with the average run of cases of this age. Pure tone audiometric studies in a free field will also not work unless it is associated with a condition type of test such as the "peep show" or the 'Podi-Acoumeter." Unfortunately, I have no access in Newark to a "peep show" type of audiometer. I have been forced to rely upon either association of pure tones with play games or cards or musical toys such as various pitch whistles, bells or pipes. We have access to psychogalvanometric testing in Newark, but I had no experience with the use of EEG with an arousal response.

In this group we often throw together children with no speech understanding at all, aphasics, mental defectives and severe emotional problems. For practical purposes it makes little difference whether a child has little residual hearing or a moderate amount at this age. His education for the first few years would be the same as if he were totally deaf. No harm has been done if, after a few years under this type of treatment, it is found that a child has more hearing than previously indicated. It would be worse if the child of this age were not treated as though he were deaf. Valuable time may have been lost.

Recognition of hearing defect should be made and education should be started in the pre-school rather than in the school child. Valuable time is lost waiting for the child to reach the school program.

THE PARENTS

THE second part of this, and often a major problem is the parents. They are often reluctant to accept the truth. We have not been weaned from the ancient, often subconscious, resentment about a defect in the family. Parents must often be educated to the clear understanding that a hearing defect is not a stigma, but something to be accepted, with all efforts being made to correct or rehabilitate. Parents often take a skeptical view of the entire situation, including medical and surgical recommendations and recommendations as to education and rehabilitation. They should be encouraged to join active and interested parent-teacher associations, where they have contact with the common problem of their hard of hearing children. Parents must be encouraged to join local societies of the hard of hearing, where education, encouragement and enlightenment are given. A good source of education on this subject is *Volta Review*.* The parents must be advised, consulted, made a part of the program for the rehabilitation and care of these children. Without such firm cooperation with the parent, the problem is more difficult.

Now we reach the stage where the parent is fully informed, a diagnosis has been made and some evaluation of the residual hearing accomplished.

We see some cases that might be attributed to Rh incompatibility, pre-natal measles, streptomycin toxicity, and a large group of serous

*Published by the Alexander Graham Bell Association at 1537 N. W. 35 Street, Washington, D.C. and obtainable from that organization.

otitis media with its sequellae, unfortunately, due to total reliance upon chemotherapy and antibiotics without adequate drainage. The problem now resolves itself into education and follow-up of these children.

EDUCATION

EDUCATION is based upon proper placement of these children, auditory training, speech training, speech and language education, vocational guidance and psychologic and emotional adjustment. Education includes the parent. In Newark, we arbitrarily divide all the hearing problems of these children into four classes:

(1) Children who have losses up to 20 decibels in any one or more of the speech frequencies. In this group all necessary medical, and surgical procedures have been accomplished. The child is given central front seating. Occasionally speech training is given, if necessary, and observation and rechecks are made at frequent intervals.

(2) Those children who have a 20 to 35 decibel loss. All necessary medical and surgical procedures have been accomplished and if not, are stressed. Front central seating is recommended. They may or may not be referred to a hearing conservation class. A hearing aid may or may not be prescribed, depending upon their psychologic adjustment and ability in school.

(3) Thirty-five to sixty decibel loss. These children are referred to hearing conservation classes. All necessary surgical and medical procedures are insisted upon. Hearing aid, audiometry training, speech reading, speech training, are all advocated nearly routinely.

(4) Those children who have a loss above 60 decibels. These children are referred to Bruce Street School, which is a full-time school for the deaf. Here they receive routine auditory training, speech reading, speech training, speech, language and voice training, vocational training, and psychologic adjustment. These children receive oral training only. There is no provision for manual training, which is not recommended in this school system at all.

Most children who have a defect above 30 decibels are referred to hearing conservation classes, in various schools, placed throughout the city. There is a full-time, experienced, highly-trained teacher of the deaf at each school. The child attends his regular class and is given the necessary training. Some children in this group need hearing aids; others need only a moderate amount of speech and language training; others must be taught speech reading. The instructor of the deaf works in close cooperation with the homeroom regular teacher. If a child is noticeably deficient in any one subject, aid in that particular subject is given by the teacher of the deaf at the time of the auditory or speech training. Each child is given the time on an individual basis which he requires. In the School for the Deaf in Newark in the last two or three classes, vocational type courses are given in close conjunction with various industries in the neighborhood and the school itself. There is no provision in Newark for high school education in the group in Class number 4, the group which we label deaf. However, for the hard of hearing group who go on to high school, arrangements are made with the nearest hearing conservation classes and the hard of hearing high school child spends the appropriate number of hours at such hearing conservation classes until graduation from high school.

SUMMARY

THE problem of hard of hearing in the school age child, in many cases, has its inception in the pre-school age. Here is where recognition of such defects should begin, and where rehabilitation should also begin. It should become a matter of community interest to see that all children not now covered by the school age program be given the benefit of such program at the earliest age possible. The loss of much valuable time could be avoided in this manner, when one considers that educationally, a hard of hearing child is two or three years behind his normal hearing brother. The problem then lends itself to early recognition of hearing defect, parental education and cooperation, education and rehabilitation of the child and a close follow-up system.

31 Lincoln Park

Felix Salerno, M.D.

Dallas, Texas

Joel Cherashore, M.D.

Elliott Middleton, M.D.

Montclair

Anaphylactoid Reaction to Bromsulphalein*

Bromsulphalein can cause anaphylactic reactions. It is sometimes advisable to administer an antihistamine prior to the test.

During 1960, 411 bromsulphalein (BSP) tests were done at The Mountainside Hospital. The case reported below was the only one complicated by a severe systemic anaphylactoid reaction. Other reactions that have been noted were local pain, minimal perivascular infiltrations leading to localized inflammations and occasional thrombophlebitis.

A 47-year old man entered the emergency room because of severe generalized pruritus and angioneurotic edema. He had had an upper respiratory infection during the week prior to admission. He had been drinking wine during that week. The evening prior to admission, the patient had taken four proprietary pills† and two more pills the morning of admission because of low back pain.[8] The night prior to admission, he did not sleep because of restlessness, slight pruritus and discomfort due to swelling of his eyelids. The morning of admission he drank some wine after leaving home, ate oysters for lunch and returned home complaining of generalized pruritus and severe edema of the eyelids. The patient vomited once on the way to the emergency room.

In the emergency room, he was found to be in respiratory distress with a blood pressure of 60/0, pulse 102 per minute, respirations 24 per minute, angioneurotic edema involving the eyelids, lips and pharynx, a faint erythematous rash over the trunk and extremities and bilateral wheezing on examination of the lungs. The diagnosis of anaphylactoid reaction to an unknown substance was made. Immediate treatment consisted of aqueous epinephrine 0.5 milliliters subcutaneously, Benadryl® (phenhydramine hydrochloride) 25 milligrams intramuscularly followed by hydrocortisone 100 milligrams intravenously and epinephrine in oil 0.5 milliliters intramuscularly. Following improvement, the patient was admitted to the ward where it was learned that five years prior to admission he was treated for an urticarial reaction to wine and warned never to drink it again. He also had a past history of urticaria after eating tomatoes and symptoms of hay fever in the late summer over the past 20 years.

At this time, an odor of alcohol was detected on his breath; the blood pressure was 126/74, pulse 120, respirations 16 and rectal temperature 96.4. There was marked swelling of both eyelids with conjunctivitis but wheezing was no longer present. The only other pertinent positive finding was a smooth, non-tender liver palpable 6 centimeters below the right costal margin.

The urine showed plus-minus proteinuria, 0 to 3 red cells, 5 to 25 white cells, occasional pus clumps and 0 to 2 coarsely granular casts per high power field. Subsequent urinalyses showed persistent pyuria but no red cells. The hemogram was normal on admission with 2 per cent eosinophils. Blood urea nitrogen was 12.5 milligrams per cent, the Kolmer, Wassermann and VDRL tests were negative. Chest x-ray was normal. An electrocardio-

*This is from the Department of Medicine, Mountainside Hospital, Montclair, N. J. Dr. Salerno is now at the Baylor University Medical Center in Dallas, Texas.

†This proprietary pill, according to the manufacturer, contains: "theobromine sodio-salicylate, sodium salicylate, extract uva ursi, extract buchu and vitamin A."

gram, taken when the patient was normotensive, showed diaphasic T-waves in Lead II and inverted T-waves in Leads III, AVF and V1 through V6. Three days later all previously negative T-waves had become positive. The liver studies obtained on admission and subsequently are shown in Table 1.

Because of the history of alcoholic intake and abnormal liver chemistries on admission (Table 1), a liver biopsy was performed four days after admission. This revealed anatomic changes consistent with a diagnosis of nutritional cirrhosis. On the seventh hospital day, a bromsulphalein (BSP) test was done using 5 milligrams per Kilograms of body weight. Within one minute the patient felt weak and developed profuse diaphoresis. Shortly thereafter, he was found to have severe angioneurotic edema, nasal congestion, pulmonary wheezes and hyperactive bowel sounds. He vomited once and his blood pressure was then 70/50. The patient responded to epinephrine 0.3 milliliters intramuscularly, Aramine® (metaraminol) 2 milligrams intramuscularly and hydrocortisone 100 milligrams intravenously. Liver chemistries were done after the reaction and repeated the following morning (Table 1). In addition, an electrocardiogram done at this time was essentially normal.

Following discharge from the hospital, intradermal skin testing was done in the clinic using 0.1 milliliter of 1 to 1000, 1 to 100 and finally 1 to 10 dilutions of bromsulphalein dye. All the tests were negative at 24, 48 and 72 hour readings.

TABLE 1.

LIVER FUNCTION STUDIES

Day After Admission:	1	5	6*	8†	9	90
Bilirubin (mg.%)						
Direct (1 min.)	0.7	.	0.6	..	0.35	0.15
Total	2.1	.	1.1	..	1.4	0.9
SGO Transaminase	400	..	77	79	50	20
SGP Transaminase	..	92		87	67	6
Cephalin Flocculation (48 hours)	2+		neg.		+	neg.
Thymol Turbidity	8	..	4.5	..	4.5	2.0
Alkaline Phosphatase (Bodansky Units)	8.2		6.9	..	5.3	4.8
BSP Test (dye retained after 45 minutes)	.		.	.12	.	..
Prothrombin Time (sec.)	15	..	.	..	14	..
Sedimentation Rate (mm./hr.)	24	.	.	..	95	30

*Date of liver biopsy.
†Date of follow-up studies in outpatient clinic.

The first severe systemic reaction to intravenous bromsulphalein was that reported in 1948 by Chamber and Moister.[4] Since 1948, 17 cases have been cited, and this is the 18th such case. The exact cause of the initial reaction in our case—that is the factor which required hospitalization—is undetermined. The outstanding possibilities include (1) excessive ingestion of wine (which may be a source of mold-derived products to which this patient may have been allergic), (2) allergic reaction to oysters eaten immediately before admission and (3) a drug reaction induced by some constituent of the proprietary pills.[8]

Regardless of the exact cause, at the time of hospitalization it is clear that many of the findings could be attributed to endogenous histamine release (pruritus, erythema, urticaria, angioneurotic edema, hypotension, dyspnea and wheezing). The response to epinephrine and Benadryl® (phenhydramine hydrochloride) is consistent with this view.

The sequence of events at the time of BSP administration leaves no doubt that this compound was responsible for the immediately ensuing reaction which again was histaminic in nature. The question remains, however, whether this was a truly allergic (antigen-antibody) reaction or resulted from a direct histamine releasing activity of bromsulphalein in this individual, without the intervention of an immunologic mechanism.

For an immunologic mechanism to be operative, it is necessary to postulate that the bromsulphalein acted as a hapten to form a complete antigen with subsequent antibody formation with BSP specificity. Although this patient had never been exposed to bromsulphalein before, he had almost certainly had contact with phenolphthalein, the familiar cathartic which is the unhalogenated form of BSP. Previous sensitization to phenolphthalein might have set the stage for the reaction to bromsulphalein.

In drug reactions it is often found that an antibody cannot be demonstrated by skin tests or serologic technics. This fact, together with the knowledge that many drugs in human use can act as histamine liberators[16] by a direct pharmacologic action, causes speculation as to

whether this type of reaction may account for the effects of bromsulphalein in our patient.

An interesting finding in this patient was the generalized T-wave inversions on the electrocardiogram taken following the therapy for the initial reaction which included a milliliter of epinephrine. Prior to this case, a 53-year old man had been admitted to this hospital following an anaphylactic reaction to intramuscular penicillin. An electrocardiogram taken when the patient was normotensive after having been given 0.5 milliliter of aqueous epinephrine showed similar generalized T-wave inversions which improved on serial tracings. These two cases demonstrate the known electrocardiographic changes in man that are reported as being secondary to epinephrine.[5]

COMMENTS

In view of the fact that the bromsulphalein test is such a frequently used index of liver function, this case is being presented along with a review of the literature concerning known reactions to the drug.

A complete historical review of the work leading up to our present-day bromsulphalein test would be too lengthy for this report. However, among others, the original research done by Abel and Rownree[1] in 1909 on the properties of various phthaleins and their derivatives must be mentioned as it led to further work[22,23,29] in 1913 using these substances as a test of hepatic function. It was not until 1922, that Rosenthal[18] employed the disodium salt of phenoltetrachlorphthalein intravenously and, for the first time, studied the blood stream clearance instead of fecal percentage of the dye. In 1924, Rosenthal and White[19] reported on the toxicity of bromsulphalein and in 1925, they reported[20] on its use in normal individuals and those with liver disease. Rosenau[17] in 1925, summarized the following reactions to halogenated phthaleins: (1) thrombosis, (2) local reactions at the site of injection, (3) chills and fever, (4) questionable deaths due to thrombosis in large vessels, (5) miscellaneous reactions as pain over liver region and a purgative action, (6) urticaria, (7) generalized skin reaction, (8) anaphylactoid reaction and (9) death.

Presently, there are still various opinions regarding the best test dosage and blood sampling times. The most commonly employed procedure at this time is a dose of 5 milligrams per kilogram of body weight with collection of serum for per cent retention 45 minutes after the injection of the dye as advocated by Mateer *et al.*[12] in 1943.

Chambers and Moister[4] in 1948, reported the first severe systemic reaction to intravenous bromsulphalein. Subsequent to this report, we have been able to find sixteen additional cited cases of severe systemic reactions; the present one brings the total to eighteen. Various factors brought to light in a study of these cases are summarized in Table 2. One of the eighteen cases reported by Deutsch *et al.*[6] was that of a severe generalized coalescing morbilliform rash occurring in a 44-year old male who had received bromsulphalein for the first time with no previous allergic history. Subsequent skin test with a cubic centimeter of 1 to 10,000 dilution of bromsulphalein was negative as was a BSP patch test.

The possibility of a fixed sensitization (a previously affected area which can be activated by re-exposure to a drug or excitant) was studied in 1949 by Sievers *et al.*[23] because of an interesting phenomenon that occurred in their case. In their patient the bromsulphalein dye had been injected paravascularly in the right antecubital fossa and a localized reaction occurred. One month later a repeat BSP test done in the left arm caused a severe systemic reaction as well as a recurrence of the localized reaction in the right arm at the site of the previous reaction. Skin testing was done using a 1 to 100 dilution on both forearms and found to be positive only in the area of the right forearm where the previous reactions had occurred. A positive skin test was also demonstrated using tetrachlorphthalein instead of tetrabromphthalein; a halogen-free analogue did not cause any reaction. A most interesting observation was that an antihistamine given prior to the skin test abolished the positive reaction.

SUMMARY

1. A non-fatal anaphylactoid reaction to bromsulphalein in a 47-year old man with an allergic history and a review of the existing reported cases in the literature has been presented. The present case is the eighteenth reported incident of a severe systemic reaction to intravenous bromsulphalein.

2. A review of the literature revealed the following: (a) six have been fatal reactions and twelve non-fatal; (b) five had an allergic history; (c) for five patients it was their first exposure to bromsulphalein dye; (d) the dose used in all but one case was 5 milligrams per kilogram, and (e) when skin testing was done, the results were positive in three cases and negative in two.

3. In conclusion, it would appear that from the available data the presence or absence of an allergic history is not a determining factor in predicting reactions to bromsulphalein. A negative skin test does not rule out the possibility of a reaction occurring. However, when a positive allergic history is present, it may be advisable to administer an antihistamine prior to the test.

TABLE 2.

Case Number	Previous Exposure to BSP	First Exposure to BSP	Allergic History	Dose Used mg./Kg.	Skin Tests	Bibliography References
Six Fatal Reactions						
1	..	Yes		5 mg./Kg.	-	2. Björneboe, M.
2	.	..		5 mg./Kg.	..	10. Kothe, J.
3		Yes	No	5 mg./Kg.	..	11. Mallin, S. R., *et al.*
4	Yes	.	Yes	5 mg./Kg.	..	25. Stecher, J. L.
5	.	Yes	Yes	5 mg./Kg.	..	26. Venger, N.
6	Yes	.	No	5 mg./Kg.	..	27. Walker, H.D., Jr., *et al.*
Twelve Non-Fatal Reactions						
1	..	..		5 mg./Kg.	..	3. Caroli, J.
2	..	..	Yes	5 mg./Kg.	..	4. Chambers, W. N., *et al.*
3	..	..	No	2 mg./Kg.	1.10 neg.	5. DeAndino, A. M. Jr., *et al.*
4	..	..	No	5 mg./Kg.		6. Deutsch, D. L., *et al.*
5	..	..		5 mg./Kg.	..	7. DiCaprio, J. M., *et al.*
6	Yes	..		5 mg./Kg.	1.1 pos.	13. McVay, L. V., Jr.
7	Yes	..	No	5 mg./Kg.	1.100 pos.	14. Morey, G., *et al.* 23. Sievers, J.J., *et al.*
8	Yes	..	No	5 mg./Kg.	..	15. Nedwicki, E. G., *et al.*
9	..	Yes	No	5 mg./Kg.	..	15. Nedwicki, E. G., *et al.*
10	..	..	Yes	5 mg./Kg.	..	21. Roth, J. L. A.
11	..	..	..	5 mg./Kg.	..	24. Soubigou, X.
12	.	Yes	Yes	5 mg./Kg.	1.1000 1.100 1.10 neg.	Present case

3500 Gaston Avenue (Dr. Salerno)

A selected bibliography of 29 citations will be found in the authors' reprints.

Howard B. Miller, M.D

Fairlawn

The Cell: Normal and Malignant*

Most clinicians think of the cell as a static and neatly stacked structure. In truth, it is alive, constantly in flux. Until we can understand cell dynamics, we cannot understand malignancy.

After centuries of affliction, cancer is today's enigma and today's target. From all angles, research is seeking the underlying causative mechanism. To understand the malignant cell, it is essential to grasp today's dynamic concept of the normal cell, and to realize the pitfalls down the road leading to the diagnosis of malignancy. Cytologic studies have been jet-propelled by electron microscopy, intra-cellular chemistry and micro-dissection technics. Thus, research is gradually moving from histopathology toward cytopathology.

The widespread acceptance of the Papanicolaou tests has been one of the greatest contributions to early detection of many types of cancer. It has been demonstrated that careful microscopic study of individual exfoliative cells from body cavities and fluids (vagina, uterus, lung prostate, colon, stomach and others) can reveal malignant change long before the appearance of a visible lesion. Thus, its use as an adjunct to the time-honored procedure of biopsy has vastly expanded the field of early cancer detection.

MYTHS ABOUT MALIGNANT CELLS

Many false ideas concern malignant cells. Among these fallacies are the following:

False: A cell is malignant if it can metastisize.

Fact: Certain tumors of the central nervous system are known to be malignant, yet rarely metastisize.

False: Autonomous cellular multiplication uncontrolled by usual reproductive mechanisms is thought to be characteristic of malignant cells.

Fact: Definite growth control has been demonstrated in certain strains of tumors. Cells of these tumors almost all have special characteristics of growth rates, and each type of tumor varies considerably.

False: Malignant cells stain heavier than normal cells.

Fact: Staining characteristics vary markedly. Any cell in a rapid growth state (or affected by infection and inflammation) may take a much heavier stain than a normal cell.

Some doctors depend upon nuclear changes to diagnose cancer. Such changes (nuclear enlargement, hyperchromasia, irregular deposition of chromatin) are *not* specific to malignant process. They are criteria only of a marked shift in balance between the catabolic and anabolic metabolism of the cell components. Also, any process which increases the rate of cell growth abnormally can also produce atypical nuclei, non-malignant as well as malignant. Such examples of non-malignant atypia are found in vaginal smears from pregnant women, from women with chronic cervicitis, from areas stimulated by recent cautery, or chemical or radiologic applications. Cells in such specimens differ from malignant ones only in the *degree* of change.

Accurately to pinpoint "the" charcteristics of a malignant cell is a demanding task. Observ-

*This work comes from the Cytology Center at Fair Lawn.

able changes are qualitative rather than quantitative. There is no black and white, only a wide field of overlapping shades of grey. Experience and skill are needed before a final diagnosis can be made.

Today's knowledge of the normal cell has expanded in an explosive manner. It is essential that we acquaint ourselves with the highlights.

THE NORMAL CELL

UNTIL recently, our concept of the cell was that of a mass of protoplasm, containing an isolated nucleus. A speck within the nucleus was called the nucleolus. The nucleus was known to consist of threads of chromatin and two dots of matter called centrioles, which "came alive" only when the cell divided. These parts were considered more or less isolated from each other. Today, we know differently. We realize that the cell is certainly not a stagnant pond containing isolated islands of matter. Instead, is is a living, dynamic structure with complete interaction and interfunctioning of each part upon the other. No longer is the nucleus considered asleep or independent of the rest of the cell.

Chemicals pass from the nucleus out and from the cytoplasm in and *vice versa*, each shaping and directing a function of the other. Research has brought to light other vitally important structures of the cell besides the nucleus and the cytoplasm. These newer entities are the seven listed below.

ENDOPLASMIC RETICULUM

A MESHWORK of tiny canals, one-twelve-millionth of an inch wide, lace the cytoplasm. It is believed that substances pass through these canals dispersing throughout the cytoplasm and even to the outside, as well as to the nucleus—thus providing a channel reaching to the outer cell membrane directly from the nucleus itself. This is the endoplasmic reticulum.

RIBONUCLEAR PROTEIN OR RIBOSOMES

TINY particles of matter exist throughout the cytoplasm mostly attached to the canals. They are important in the control of the manufacture of proteins, mainly *ribonucleic acid*. They get their energy from chemicals developed in the mitochondria.

MITOCHONDRIA

A GRANULAR-FILAMENTAL network, the mitochondria constitute the powerhouse of the cell: the cell's dynamic. It is here that glucose in converted into chemical energy. Mitochondria will be described in more detail further in this paper.

GOLGI APPARATUS

WITHIN the cell is a reticulum, Golgi's apparatus, a storehouse for chemical energy. Each element of the apparatus consists of four or five small units of curved, hollow, overlapping plate-like structures stacked on top of each other. The entire unit resembles an active mechanism like a storage battery. Each sheet is one thousand to two thousand millimicrons long and one-hundred millimicrons thick. This apparatus is found in all cells. They appear to be involved in secretory activities and are most prominent in mucous cells, and endocrine and exocrine glands. In neurons, they are believed to have a special secretory significance.

LYSOSOMES

LYSOSOMES are small, sac-like areas containing chemicals capable of dissolving the entire cell. They are believed to play an important part in destroying the afflicted cell and its invaders in a disease process, in an attempt to dissolve the invaders before they can reach other cells. This is a sort of inbuilt "scorched-

Earth" defense. They are spheroids, 300 to 400 millimicrons in diameter, filled with hydrolytic enzymes and surrounded by an impermeable lipo-protein membrane. Under greatly adverse conditions, the cell commits hara-kiri by opening the sacs and allowing itself to be destroyed.

THE OUTER COVERING

IN MANY cells, the outer covering is more than a mere plastic shell. Sometimes, the outer membrane is covered with thousands of finger-like extensions called *microvilli.* It may be pitted with small wells, called *pinocytic vesicles.* These depressions and extensions apparently increase the absorptive functions of the cell membrane enabling it also to incorporate macromolecular material, like viruses.

SEX CHROMATIN

THERE is a sex differentiation in the structure of the cell nuclei in man and other mammals. A small blob of chromatin is visible in the resting nuclei of females but not in those of males. This sex chromatin found in female nuclei usually adheres to the inner surface of the nuclear membrane.

Chromatin sex determination is now routinely used in diagnosing certain endocrinopathies.

Thus, the modern concept of the cell is a dynamic one. The nucleus moves slowly through the cytoplasm. Mitochondria glide through it. The endoplasmic reticulum may tremble like a tree in the wind. Chemical substances flow from one part to another.

THE NUCLEUS

THE basic substance of the nucleus is known as chromatin. This intense, threadlike meshwork is composed of nucleic acids. These include desoxy nucleic acid (DNA) and ribonucleic acid (RNA). Chromosomes and genes are smaller particles of nucleic acid aggregates. Genes are believed to contain the specifities of cell proteins and also the balance of metabolic reaction rates. We cannot yet measure the gene itself, but we can measure (by electrophoretic differences and enzymatic activity variations) the gene product, the protein molecule. It is now believed that the DNA nucleus protein of the genes is *the* hereditary substance.

The wall surrounding the nucleus was long thought to be a single membrane. Now, however, it is known to consist of two membranes, about 20 millimicrons apart, studded with openings. These nuclear pores apparently serve as a two-way sluice gate between cytoplasmic and nuclear material.

The protein of the nucleus includes at least four components: (1) DNA; (2) RNA; (3) Histone and (4) Nonhistone protein.

(1) The DNA‡ of the resting nucleus is in relation to the number of chromosomes and is, therefore, characteristic of each species. The DNA content of each chromosome set is relatively constant.

(2) RNA† is believed to be formed in the nucleus—the major part of which then finds its way to the nucleolus. There it remans until needed by the rest of the cell. Then it passes into the cytoplasm.

(3) Histone is a protein, basic in reaction (electro-positive), because it contains large amounts of the amino acid "Argenine" and histidine.

(4) Non-Histone Protein ("chromosomin") is a less basic protein than histone. The DNA and the histone base are tightly linked.

CHEMISTRY AND NUCLEAR VOLUME

DNA‡ includes nucleochromatin, genes and chromosomes. The nucleolus is RNA† with just a rim of DNA. During cell division, DNA content in a chromosome is maximum and most intense in the area of genes. By additions, alterations in content, and distribution of these chromosomal nucleic acids are correlated with

‡Desoxynucleic acid.
†Ribonucleic acid.

genetic changes. Therefore, the DNA‡ is considered a prerequisite for the reproduction of the genes. The RNA† is considered to play a key role in protein synthesis.

The increase in nuclear volume may be due to any or all of the following:

1. Increase in DNA‡ alone.
2. Increase in the number of chromosomes (*polypoidy*).
3. Increase in the number of strands in each chromosome (*polyteny*).

Here in *polypoidy*, the mechanism observed is that of reduplication and enlargement of chromosomes, as if ready for cellular division, but never achieving it. This chromosome reduplication can occur even within the intact resting nucleus as well as in any phase of the mitotic cycle. It should be noted that those chromosomal changes can be brought about by x-ray and chemical effects. They are *not* necessarily unique to cancer cells.

The number of chromosomes in man is accepted as 48 except for reproductive cells; here, there are only 24 matched during fertilization by similar chromosomes from the opposite sex. Recent work, however, indicates that the number of chromosomes should be regarded as 46. It is not the number of chromosomes, but the number of genes that determines the characteristics of any species. There are between 5,000 and 25,000 genes in the human cell. Each gene may be a single nucleo-protein, and may control one or more characteristic.

NUCLEOLUS

THE nucleolus is composed mostly of RNA† with only the outer rim consisting of DNA.‡ The nucleolus is not a homogenous structure. It consists basically of clusters of small granules, mostly RNA,† averaging 10 to 15 micra.* These closely packed granules are arranged as broad, anastomising chords between which is nucleoplasmic substance.

No nucleolus membrane has ever been demonstrated.

During normal cell mitosis, the gross compact structure of the nucleolus is rearranged into a new structural pattern and is apparently closely associated with certain chromosomes.

The material of the nucleolus flows freely into the cytoplasm. There is an interchange of material; for example, DNA‡ between the nucleus and the nucleolus.

The nucleolus is essential for protein synthesis.

MITOCHONDRIA

THESE small, compact structures found in the cytoplasm, are the power plants of the cell. Here, glucose is converted to adenosine triphosphate (ATP). This is the universal intracellular carrier of chemical energy. The exothermic energy derived from this glucose oxidation through the steps of the Krebs Cycle, is converted to the potential energy stored in the "high energy" phosphate bonds of adenosine triphosphate. The energy-rich ATP molecule can travel wherever energy is needed in the cell to furnish the drive for energy-consuming functions, from the contractions of the muscles to the synthesis of protein. The enzymes involved in both the citric acid and respiratory cycles are in the mitochondria.

Anatomically, mitochondrium is a tiny, oblong or rodlike structure in the cytoplasm. A single cell may contain several thousand such bodies which together may account for 20 per cent of the total weight of the cell. It is a highly organized structure, consisting of an outer enclosing membrane, separated by a thin space from an inner membrane which at varying intervals is thrown up into folds to form "cristae," resulting in a semi-compartmented space, the inside of which is filled with a semi-fluid "matrix."

THE MALIGNANT CELL

WE MAY now consider the general characteristics of the malignant cell, under these

*A micron is one thousandth of a millimeter. There are about 25,000 micra to an inch.

headings: (1) cytoplasm; (2) nucleus; (3) nucleolus.

(1) The *cytoplasm* does not undergo (so far as we know) any consistently demonstrable change.

(2) The *nucleus* shows variations. The size and shape of malignant nuclei vary within wider limits than do the cells of the normal tissue from which they develop. These variations are due primarily to chromosome changes. The principal such changes are:

A. Chromosomes are thicker and more "sticky," and (as a result) interchromosomal bridges develop. These changes delay and alter chromosomal separation in various stages of mitosis, especially the anaphase stage resulting in many chromosomal abnormalities.

B. *Polypoidy*: Changes in the number of chromosomes are often irregular and may be due to a degree incompatible with further propagation.

C. The changes listed above cause abnormalities which are particularly noted in the spindle, such as partial or complete suppression, or the development of multi-polar sites.

All of these observable nuclear changes, however, can be brought about by chemical toxic agents. Yet a cancer cell is *not* produced by inducing one or all observable changes synthetically. Aberrations can thus be produced but cancer is not. The question is often asked: Can abnormalities themselves bring about the malignant transformation, or *vice versa?* The nuclear mass itself owes its increase in size, and variation in shape to the increase in the number of sets of chromosomes primarily.

3) The *nucleolus* definitely undergoes in malignancy, observed and demonstrated by:

A. Increase in size.
B. Change in shape.
C. Multiple nuclei.
D. Fragmentation.
E. Consolidation.
F. Vacuolization.

There are even well-observed and documented pre-cancer changes recognizable in the nucleolus. These include disturbances of nucleolar colloid; and disturbances of nuclear organized material directly through the nuclear membrane into the cytoplasm from the inclusion bodies.

CHEMICAL CHANGES

TO DATE, there has been no demonstrable, unique difference in the cytochemical analysis between malignant and normal cells. Studies to establish general blood serologic tests for cancer are still in the experimental stage. The detection of a specific soluble antigen to sera of cancer patients is being sought and is highly promising.

The tests are based on the assumption that cancer cells release into the circulation an unidentifiable protein specific to cancer tissue. Antigen-antibody tests utilizing the various biologic assay methods and chemical tests to determine and identify the substance are well underway.

The term, *nucleic acid,* is a misnomer: those acids are *not* confined to the nucleus; they are in the cytoplasm as well. The two main nucleic acids are DNA‡ and RNA.† DNA‡ is found almost exclusively in the nucleus. RNA† is found in the cytoplasm, but 10 per cent of it is detected in the nucleus. Recent work suggests that RNA† is first formed in the nucleus, then transferred to the nucleolus and cytoplasm. Evidence now tends to show that the common denominator of all life may be nucleic acid as found in the nucleoprotein. All living things have, in their basic core, nucleic acid acting in combination with certain nucleoproteins.

Nucleo-protein is a protein consisting of nucleic acid and a specific protein. It is made up of a long chain of "nucleotides," linked to each other *via* a bridge of inorganic phosphate. This *nucleotide* is a primary building block, composed of a nitrogen-containing base (ex-purine and pyrimidines) linked to a sugar molecule, which is always a pentos (5-carbon) sugar, unlike glucose, which is a 6-carbon sugar.

The *purines* are adenine and guanine. The *pyrimidines* are thymine, cystosine and uracil. Both RNA† and DNA‡ contain adenine and guanine.

Nucleic acids are very large molecules. The molecular weight of DNA equals 8,000,000. They are asymmetrical. The molecule can be visualized as flat plates of nucleotides, layered

on top of each other, and joined to each other by a verticle thread of an inorganic phosphate bridge.

DNA‡ appears to have a vertical configuration composed of two parallel nucleotide chains twisted about a central core.

Self-duplication of nucleo-protein. The mechanism of auto-reproducibility appears to be similiar in genes, viruses and phage particles. The nucleo-protein represents a mold, a template, on which the exact image of itself can be manufactured from materials already in the cell. For example, when a cell divides, daughter cells receive the same number and kinds of chromosomes as parent cells. This apparently does not result from a longitudinal splitting into two equal halves as previously thought. Instead, each original chromosome synthesizes an exact replica of itself by the process of auto-catalysis.

It is also believed that the gene directs the synthesis of *enzymes* in much the same way as it controls the manufacture of molecular counterparts of itself. The center of genetic formation must be transmitted to the cytoplasm where most protein synthesis takes place in association with RNA.† This process is believed to occur in the following manner:

The DNA‡ of the genes in the nucleus transmits the necessary information to the small amount of RNA† in the nucleus and nucleolus. The nuclear RNA†, then passes the endoplasmic reticulum known to be concerned in protein formation. According to this concept, the DNA‡ does not directly control the synthesis of enzymes. The DNA‡ would be the genetic control, and the RNA† the metabolic control. Metabolic activities of all types are catalyzed by specific enzymes. Numerous such anomalies are now being traced to changes in a specific enzyme pattern.

Nucleo-proteins alone have been found to be capable of inducing completely new morphologic or enzmatic properties which are thus transmitted to their descendents in a genetic fashion.

Latest work suggests that nucleic acid alone, without the intact virus, can cause death of an involved cell. After all a virus is basically a nucleic acid, plus a protein covering.* Nucleic acid alone can stimulate an inoculated cell to reproduce the entire intact virus. Experimentally, the following observations help lead to these conclusions:

A. Tissue cultured cells were inoculated with various pure RNA† extracts, derived from the polio virus. The RNA† alone produced cytopathologic changes typical of poliomyelitis infection.

B. Researchers reported the recovery of fully potent new viruses from the brain tissues of laboratory animals given intra-cerebral injections of RNA† extracts alone.*

C. DNA‡ derived from a virus and by itself injected into a cell results in the breakup of the nucleus followed soon after by regrouping of DNA‡ into new primordial virus heads.

VIRUSES AND NUCLEIC ACID

Viruses are composed of a core of nucleic acid (DNA‡) wrapped in a layered mantle of protein (mostly "chromosin" rather than the basic histone protein). The virus consists of a tail sheath, enclosing an inner core, which functions as a hollow needle for injecting DNA‡, and a baseplate at the end of the tail. The virus apparently attacks a cell by attaching to the baseplate of the host and injecting DNA‡ through the tail needle. The empty head remains outside. The virus, therefore, is essentially a nucleo-protein. The protein portion of the virus usually governs the immunologic behavior, the DNA‡ portion apparently determines the specific disease produced. Viruses and genes often merge chemically so completely that it often becomes impossible to determine the difference between a gene and a virus. A virus may have a crystalline structure.

In 1900, Rous demonstrated that the virus itself was the direct cause of the tumor now known as Rous Sarcoma, and not merely the trigger agent of some vague characteristic of the virus demonstrated in Rous Sarcoma. It is a function of the dose of the virus used to initiate their growth. Using extremely low initiating doses, the resulting tumor may show no demonstrable virus in extraction. This is contrary to the common assumption that tumors having a viral origin should yield demonstrable virus, and that failure to do so represents evidence of "non-viral" origin.

Evidence that viruses are involved in cancer

formation is accumulating; but to date, no direct role of viral agents in human cancer has been proved. However, an interesting concept known as *transduction* has been demonstrated. This has shown that viruses can enter the nucleus of a cell and become an integral part of the gene conglomerate. The virus can then pass along with the gene into the new daughter cell, thus apparently becoming an "inherited" characteristic affecting the daughter element as it did the original cell. The virus can also break out of its gene environment and carry along with it some of the genes. When this virus, with its attached genes, enters a new cell, the artificially introduced genes become an integral part of the new genetic qualities and impart its inherited character to it.

From this experimental work, it can be visualized how cancer, if caused by a virus, can be an "inherited" characteristic and how the cancer changes can spread from cell to cell within one organism. Such transduction has not been demonstrated in man; but we know that man harbors many viruses and these pass from cell to cell and person to person. We also know that, experimentally, many viruses *are* capable of inducing malignant changes in a cell. It is also a fact that every human cancer cell has something in it which insures its reproduction. This "something" may be a gene, fragment of chromosome, or possibly a virus.

An important study has shown that by special treatment, a tobacco mosaic cirus yielded a nucleic acid preparation possessing virus activity. Thus, the links between the structure of the nucleic acid and life itself may become strongly forged. The future may yield the secret of the origin of the life processes existing in the molecular welding of nucleic acid with proteins. Recently, the National Cancer Institute reported a new, virus-induced tumor believed to provide significant information about the role of viruses in animal cancer. This may offer information for research on human virus cancer. The National Cancer Institute has stated that research on the relationship of viruses to human cancer is the "most active and provocative area in the far-flung fight against this deadly disease."

HOST REACTION TO CANCER

When tumor tissue from one animal is injected into another species, the blood serum of the latter forms antibodies against it. These tumor antibodies induced in laboratory animals by human cancer tissue can destroy the cancer cells and subsequently prevent successful transplantation of human cancer tissue. The cell destroying agents were found mainly in the lymphoid cells (blood, spleen, lymph nodes, and thymus). Clinically and experimentally, there is a resistance to cancer in some individuals and increased susceptibility in others. Thus, it is possible that there may be sufficient antigenic difference to be effective; and immunity, partial or complete, local or general, may one day be effectively induced by a proper vaccine.

Perhaps one reason the body is incapable of defending itself against malignant cells that seem to prey on other cells, is that the malignant cells are "members" of the same body and "accepted" by it. Thus, immunologic defenses are not called into action effectively as would be the case if the malignant cells were foreign invaders from some other individual.

Immunologic studies have demonstrated definite cases of proved spontaneous tumor regression. Thus, the host may, in ways yet undetermined, suppress its own tumor tendencies.

CHEMOTHERAPY

Chemotherapy is a valuable tool in the treatment of some cancers. Its value is increasing. The drugs used fall generally into the following categories:

1. *Alkylating agents*: These drugs interfere by chemically combining with significant needed chemical groups and prevent the normal metabolic activities of the cell. These drugs apparently affect nucleo-protein synthesis and chromosomal duplication. Alkylating agents include nitrogen mustard, triethylene melamine (TEM) and Triethylenethiophosporamide (TSPA) and HN_2.

2. *Antimetabolic agents*: Antimetabolites interfere primarily with the DNA‡ and RNA†

synthesis in the cells, and thus inhibit cellular growth and multiplication. Antimetabolites include methotrexate (which is amino-methyl-pteryl-glutamic acid); mercaptopurine, and fluorouracil (5-FU).

3. *Antibiotics* (amethopterin, Azaserene®, Mitomycin C® and Puromycin®) act as antimetabolites.

4. *Radioactive substances* (phosphorus, iodine, gold, cobalt, etc.).

5. *Antifolic agents.* These prevent purine and pyrimidine synthesis by folic acid.

6. *Oncolytic viruses,* which are anti-metabolites capable of competing with the formed nucleic acid chromosomal material in the tumor cell.

As far as can be determined, no cures have ever been recorded by utilizing cytotoxic drugs.

NATURE OF THE MALIGNANT CELL

MANY responsible researchers today believe that cancer may *not* be a matter of enhanced or accelerated division. It might, rather, be a slowing-up of the generative process. In a sense, malignancy is a generalized depolymerization disease with varying local tumor manifestations. Basically, it involves a depolymerization of desoxy nucleic acid with an increase in macroanionicity and solubilization for the transport. The depolymerization process involves the ground substance as well as the inter-cellular material. You are asked to consider seriously the fact that the old "increased cell growth" theory of cancer suggests that the polymerization of anabolism is outstripping the depolymerization of catabolism in the metabolic total where actually it now seems that the process of catabolism predominates clinically and chemically.

Recent work involving tritiated thymidine uptakes in human tumor tissues supports the view that carcinoma does *not* necessarily entail a speeding-up of the generative cycle, but a slowing up. The observed changes in the cancer cell reflecting chromatin disturbance is, therefore, associated with a dying cell rather than an overactive growing cell.

The accelerated research program in chemotherapy by the Cancer Chemotherapy National Service Center includes clinical research in 109 other drugs. Of these, 53 are steroids and hormones, 22 alkylating agents, 8 antibiotics, 16 antimetabolites, and 10 miscellaneous agents. More than 145 private and public hospitals are participating in this research.

In addition to the 109, which have been subjected to exhaustive screening and testing, some 50,000 synthetic chemicals a year are being studied in the search for anti-cancer drugs.

Thus cell research today is mostly in the active and growing fields of cytochemistry, electron microscopy, cellular dissection and subcellular transplantation, immunology and chemotherapy. The future will lie in the fusion of information gained from the dedicated work of this avant garde—and in the ability of us all to keeping our minds and creativeness open, alert, flexible—and alive.

25-15 Fairlawn Avenue

BIBLIOGRAPHY

American Societies for Experimental Biology: 43rd Annual Meeting, New York City, 1961.

Barnard, R. D.: Personal communication to the author. Dr. Barnard is consulting biochemist, New York City Health Department.

Bond, V.: From a study filed with the Medical Research Center, Brookhaven National Laboratory at Upton (Long Island) New York.

Fruton, Joseph and Simmonds, Sophia: *General Biochemistry.* New York, 1955, Wiley. Pages 284 to 386; and pages 520 through 524.

Johnson, H.: From a thesis filed at the Medical Research Center of the Brookhaven National Laboratory, Upton (Suffolk County) New York.

Kopac, M. J.: Personal communication to the author. Dr. Kopac is in the Biochemistry Department at New York University, and the communication concerned his work on the transplantation of subcellular particles by micrurgy.

Lehninger, Albert L.: Journal of Biologic Chemistry, 234:465 (Sept.) 1959; *also* his paper in the 1955 Harvey Lecture series 49, page 176.

Rappoport, M.: Work at the Sloan-Kettering Institute for Cancer Research.

Stanley, W.: Annals of the New York Academy of Sciences, 71:1100 (1959).

Zinder, N. D. and Lindenbrugm, J.: Journal of Bacteriology, 6:679 (1952).

Trustees' Minutes

JUNE 16, 1963

A regular meeting of the Board of Trustees was held on Sunday, June 16, 1963, at the Executive Offices. For the full information of the membership, detailed minutes are on file with the secretary of each component society. A summary of the significant actions follows:

Rutgers Medical School . . . Noted that the President, Dr. Jerome Kaufman, has been invited in his own person to serve as a member of the advisory committee on the new medical school at Rutgers University.

Bicentennial History . . . Designated Dr. Fred Rogers as the "responsible head of MSNJ's bicentennial history (1966) project."

THE JOURNAL . . . Complimented the Publication Committee for its diligent work and adopted its recommendations, as follows:

1) That MSNJ—as of January 1, 1964—discontinue the services of the Orange Publishing Company as printers of THE JOURNAL.
2) That the Hibbert Printing Company of Trenton be named as the official printer of THE JOURNAL as of January 1, 1964, to succeed the Orange Publishing Company.

Model Constitution and Bylaws . . . Adopted a model constitution and bylaws "for use as a guide and as a service to the component societies."

Medicare Contract . . . Authorized MSNJ officials to execute documents which expired on June 30, 1962, as follows:

1) Supplemental Agreement #3205—that the final negotiated claim rate for the period 7/1/61-6/30/62 shall be $2.94 for each claim processed and paid.
2) Final invoice (resubmission) for $1,133.62, representing the difference between the total expenses incurred over and above the reimbursements received from the U.S. Army for the period 7/1/61-6/30/62.
3) Three Party Release Form, Three Party Assignment Form, and Cumulative Claim and Reconciliation Report for the period ending 6/30/62.

. . . Authorized MSNJ officials to execute supplemental Agreement #13601, as follows:

On and after 7/1/63, accompanying dependents of members of the armed forces of the NATO countries stationed in or who are passing through the U. S. shall be entitled to the same medical care provided under the 1963-64 contract to the dependents of members of the armed forces of the U. S.

Auxiliary Programs . . . Adopted the proposed programs of the Woman's Auxiliary for 1963-64, as amended. (A full copy is available upon request.)

1964 House of Delegates . . . Adopted the following schedule for the 1964 House of Delegates:

1st session, Saturday, 5/16/64
2nd session, Sunday, 5/17/64 (election)
3rd session, Tuesday, 5/19/64 (divided into two meetings—morning and afternoon—with a luncheon recess)

State Board of Medical Examiners . . . Approved, in the order of preference indicated, the following nominations for submission to the Governor to fill expiring terms of four members of the State Board of Medical Examiners:

Incumbent—David B. Allman, M.D., Atlantic City
Nominees
1. David B. Allman, M.D., Atlantic City
2. Lloyd A. Hamilton, M.D., Lambertville
3. Raymond A. McCormack, M.D., Trenton

Incumbent—F. Clyde Bowers, M.D., Mendham
Nominees
1. F. Clyde Bowers, M.D., Mendham
2. Nicholas A. Bertha, M.D., Wharton
3. Francis J. Benz, M.D., Chatham

Incumbent—Vincent P. Butler, M.D., Jersey City
Nominees
1. Vincent P. Butler, M.D., Jersey City
2. Matthew E. Boylan, M.D., Jersey City
3. John J. Bedrick, M.D., Bayonne

Incumbent—Clymont MacArthur, M.D., Newark
Nominees
1. Clymont MacArthur, M.D., Newark
2. Marcus H. Greifinger, M.D., Newark
3. John J. McGuire, M.D., Newark

Suggestions to Journal Contributors

1. The Journal is the official organ of The Medical Society of New Jersey. It is published monthly under the direction of the Publication Committee and the supervision of the Board of Trustees. Released about the middle of each month, it is sent to each member of the Society.

2. *Who may submit articles*

The Journal ordinarily accepts only original articles by members of the Society or by guest speakers at medical meetings in New Jersey. Subjects of general medical interest, rather than those relating to specialty problems, are preferred.

Members are invited to submit to The Journal any suggestions for the welfare of the Society, as well as comments or criticisms of any materials in The Journal.

Papers read at the annual meeting become the property of the Society. Not all papers, however, will be published in The Journal. Authors wishing to submit such papers to other publications must first secure a "waiver of release of manuscript" from the Editor.

3. *Method of preparation*

All material for publication (yes, *all*, from scientific articles down to the smallest items of organization news) must be typewritten, double-spaced, with liberal margins, using only one side of the paper. Each page is consecutively numbered. Use standard "letter size" 8 x 10 or 8½ x11 inch plain white paper. Carbon copies are *not* acceptable. Type on paper heavy enough to permit editing ("onion skin" or similar extra-thin paper cannot be accepted). Keep carbon copies for reference. Every care will be taken with the material submitted, but The Journal is not responsible for the loss or damage of manuscripts.

Do not abbreviate. Write milligrams per hundred cubic centimeters, not mgm per 100 cc. Write per cent, not %—except in tables. Write out numbers from one to ten. When in doubt, *write it out!* You're sure *not* to be misunderstood!

If physician-authors possess more than one degree, only the M.D. is used. Lesser degrees of non-M.D. authors or co-authors may be used. The number of names listed as authors should be kept to two or three; other collaborators are listed in the footnote.

4. *Where to submit material*

All materials submitted for publication are sent to the Editorial Office at P.O. Box 904, Trenton, New Jersey 08605.

5. *Acceptance or rejection*

The Publication Committee expressly reserves the right to reject any contribution, whether solicited or not; and the right to abbreviate or edit such manuscripts in conformity with the needs and requirements of The Journal.

Rejected articles are returned to authors, with a statement of the reasons for rejection.

6. *Order of publication*

Ordinarily, articles will be published in the order of their receipt by the office in Trenton. Articles of seasonal value and those which reflect priority of original research may be given special consideration. State presidential addresses, programs, state society minutes, obituaries, and timely organization announcements are published in the next available space. Aside from these considerations, scientific articles normally will appear in The Journal between three and twelve months following acceptance.

7. *Length of articles*

Scientific papers should not exceed ten pages of double-spaced, typewritten, standard 8½ x 11 inch sheets. Shorter papers are more acceptable and are likely to be published earlier.

8. *Illustrations*

Authors wishing illustrations for their articles will submit glossy prints or original sketches, approximately 3 x 5 inches, from which cuts or plates will be made by The Journal. The cost of making such cuts will be borne by the author, who will—after publication—receive the cuts for his own use. The cost of these cuts varies with the size and type of illustration. An estimate of the cost will be submitted to authors, upon request. Because of space limitations, we cannot accept more than three to five pictures per article.

Original artwork (graphs, formulae, etc.)

should be submitted on heavy white paper in india ink. Tables are set by the printer.

Legends for illustrations should be typed, numbered, and attached.

9. *Tables*

Tables should be simple, presenting only brief relevant data, amply spaced. Each should have its number and title above: Table 1, Title; Table 2, Title; and so on. Long, large, or complicated tables ordinarily are not acceptable.

10. *Case reports*

Carefully prepared case reports are popular with our readers. They should be introduced with a brief general statement concerning the condition or disease, telling why the case is presented. Case report follows (reproduced in smaller type) with its separate heading: Case One, Case Two, etc. Make each report compact. Include only relevant, positive laboratory and other data. Patients' names, initials, and hospital numbers must be omitted. Minimize the dates; express them as month, date, year as December 10, 1963; not 12/10/63. After the case presentation itself (again for large type) review or sum up under a heading, such as Discussion, Comment, Summary, or Conclusion. When in doubt, refer to past issues of THE JOURNAL and note the style of an article similar to the one you are preparing.

11. *Footnotes*

Footnotes must be brief and accurate. One near the top of the first typewritten page of the article should state the date of presentation and institutional origin, if any. The footnote is usually typed immediately after the author's name and town, and above the first line of the text. (There is no point in typing it at the bottom of page 1 of the manuscript. THE JOURNAL page will not correspond to the manuscript page.) In the alternative, you may set the footnote on the same page as your citations, indicating it by an asterisk. Special titles or position of the author, acknowledgments, and the like will be added according to simplicity, editorial policy, and discretion.

12. *Biblographies.*

THE JOURNAL will make every effort to publish short reference lists—preferably under ten items. Longer ones will be omitted but will, if the author requests, be included in the reprints. References should be numbered in order of appearance, the first citation to be listed as 1.

13. *Proofs*

Galley proofs of a scientific article ready for publication are submitted by THE JOURNAL to the author. Correct the proofs and return them within two weeks. Correct typographic and grammatical errors. Do not re-insert or re-write sentences, paragraphs, tables, or reports which the Editor deleted, condensed or paraphrased. When your article reaches the galley proof stage, you may not re-edit it. If you think that the Editor has misunderstood or has changed your meaning, take the matter up by correspondence with the Editor and ask for reconsideration. Unauthorized re-editing or rewriting by an author of an article in galley proof may make it necessary to reject a previously accepted paper.

14. *Reprints*

If you want reprints, order them when you submit the corrected galley proof. A reprint order blank is attached to the galley proof when it is mailed to the author.

15. *Editorials*

Editorial material is welcomed from the membership at large. Speak out, and we'll sign your name, your initials, or respect your request for anonymity, as you choose. If you don't like something we do or say, please let us in on it; we could even stand to hear about it if something happens to please you. Perhaps a "Letter to the Editor" would help you get something off your chest. We're asking for it and we have a place to put it—in THE JOURNAL, that is!

THE JOURNAL EDITORIAL OFFICE
315 West State Street
P.O. BOX 904, TRENTON, NEW JERSEY 08605

Blue Cross and Excessive Hospitalization

New Jersey Blue Cross has a new procedure requiring medical re-certification of the necessity for continued hospitalization of any Blue Cross member after 14 days of hospital stay.

Previously, initial approval extended for a period of 28 days, with re-approvals at 21-day intervals. Duane E. Minard, Jr., Blue Cross president, said the new program has won the cooperation of hospitals, doctors, and the Plan in developing new methods of assuring wise use of hospitals and the Blue Cross subscription dollar.

"The new approval program in no way infringes on the benefits to which any Blue Cross member is entitled, or on his physician's exclusive control of determining the requirements for that care," Minard said. "But the hospitalized subscriber has a responsibility, too. Doctors join us in urging every member to leave the hospital just as soon as the physician advises it."

In the vast majority of cases, patients are discharged well within the 14-day period, as evidenced by an average length of hospital stay for all subscribers of about 8 days.

Minard said the new program works like this:

1. When a subscriber is admitted to the hospital, Blue Cross will initially allow two weeks of benefits if the patient is currently eligible in all respects for such benefits.

2. If he is still hospitalized toward the end of the second week, the attending physician will be asked to sign a form, supplying medical information and an estimate of the number of additional days' care needed before discharge. The doctor will certify that continuation of the stay is necessary for care "which cannot be rendered elsewhere than in the hospital."

3. A copy of the physician's statement will be attached to the patient's chart, for review by the hospital's admissions and discharges committee. Such committees have been established in all New Jersey hospitals in a voluntary movement to control utilization of hospital facilities and thus help stabilize Blue Cross rates, which are tied to the factors of hospital costs and utilization by the subscriber.

Minard said the 14-day approval program is intended to augment several other Blue Cross and hospital programs aimed at making sure every day of hospital stay is necessary. These include professional screening by Blue Cross examiners of every claim, to make sure benefits are not provided for admissions which are not covered under the subscription certificate (such as those for diagnostic purposes or rest cures). Blue Cross annually screens out more than $300,000 worth of claims which are covered under Workmen's Compensation.

Arbitrary Exclusion of Osteopaths

In the recent case of Griesman v. Newcomb Hospital, our State Supreme Court has, in effect, ruled that a hospital cannot exclude a fully licensed physician from its staff solely because he is an osteopath. Here is a summary of our counsel's report on this case.

The Supreme Court of New Jersey recently decided that Newcomb Hospital in Vineland, New Jersey, although private (in the sense that it is non-governmental) is public in all other respects. It receives funds from public sources through public solicitation; receives certain tax benefits, and has a "virtual monopoly" in its area. As a public hospital, the Court considers itself justified in interfering with its administration. With regard to the hospital's refusal to honor the application of Dr. Greisman for its courtesy staff, the hospital relied solely on its bylaw requiring membership in the county medical society and a degree from a medical school approved by the A.M.A. Dr. Greisman is fully licensed as a physician and surgeon in the State of New Jersey. His license indicates that he is a graduate of a school of osteopathy. He practices in the Vineland area, and *Newcomb Hospital is the only hospital in that area.* The Supreme Court has taken the position that the hospital's power to pass on staff membership applications is a fiduciary power, and any applicant is entitled to have his application evaluated on its own merits, without regard to a bylaw requiring county medical society membership or an M.D. de[gree] from an approved medical school. Therefore, our [Supreme] court has ruled that a refusal to consid[er] New application *solely* because of osteopathic s[chool] arbitrary, unrelated to sound hospital standards, and not in furtherance of the common good.

Opportunities for Physicians in FTC

The Federal Trade Commission is concerned with protecting the public through regulation of false and misleading advertising of drugs, foods, medical devices, cosmetics, and related products. It reviews and evaluates the advertising claims of these commodities and provides scientific information about their therapeutic properties and safety. A broad knowledge of medicine is required as well as familiarity with research developments. The Division of Scientific Opinions maintains liaison with experts at medical schools, research institutions, and clinics throughout the country. The position entails a moderate amount of travel from headquarters in Washington, D. C.

Physicians work under administrative direction with wide latitude for the exercise of independent judgment. Physicians have the responsibility of reviewing and evaluating advertising claims, analyzing the scientific problems involved and reporting on the adequacy of available evidence to support regulatory action where the advertising is deemed to be false and misleading. When necessary, physicians consult with experts in medical schools, hospitals, and research institutions. The Division arranges for and monitors clinical studies of products. Medical officers are called upon to appraise studies submitted by drug and food companies in support of advertising claims, and participate in conferences with their representatives.

Members of the staff work closely with the Legal Division, serving as technical advisers in connection with any regulatory action which may be taken against false and misleading advertising under the law enforced by the Federal Trade Commission. Medical officers contact and arrange for the appearance of experts to testify at hearings as to the therapeutic value and limitations of drugs, devices, etc., whose advertising claims are at issue, and act as consultants to Commission trial attorneys during hearings.

The demands of the position are full-time and leave no opportunity for part-time practice. The Commission maintains a substantial flow of scientific periodicals which are of help in keeping abreast of research developments in various branches of medicine. Opportunities abound for attendance at many local medical activities, including research seminars and symposia.

The grade and salary are governed by an applicant's qualifications. Positions are available in the Division of Scientific Opinions for grades ranging up to GS-14* level for those who qualify. The multiple liberal fringe benefits of Civil Service include an excellent retirement plan, inexpensive life insurance and hospitalization coverage, and liberal sick and annual leave.

The Division of Scientific Opinions affords a stimulating experience in the public service and presents an exciting, intellectual challenge.

*Entrance salary is $15,415, with periodic increases to $19,015. As regulatory experience is acquired, opportunities for higher grades with commensurate salary increases are available.

For more information, write to Chief, Division of Scientific Opinion, Federal Trade Commission, Washington 25, D. C.

Diabetes Detection in New Jersey

The following comes from Kenneth I. Shine, M.D., of the New Jersey State Department of Health.

Diabetes detection surveys are underway in New Jersey communities. There are an estimated 60,000 or more undiagnosed diabetics in the state today. Many will benefit from simple measures such as weight reduction, diet, and oral agents if they are discovered early in the course of the disease. Weight reduction alone may cause the abnormal tolerance to become normal.

twee surveys emphasize detection of individuals evated postprandial blood sugars. A two- postprandial blood sugar of 130 or more makes the individual a diabetes suspect, and he is advised to see his private physician.

Re-testing the patient by the physician requires a two-hour postprandial blood sugar. Levels of 140 two hours after a meal containing 50 to 100 grams of carbohydrate is virtually diagnostic of diabetes mellitus if other causes of hyperglycemia are not present. In borderline cases (110 to 140) a glucose tolerance test is indicated.

Many physicians still use the fasting blood sugar in evaluating a diabetes suspect. It has been well shown that fasting blood sugar levels are commonly normal in early diabetes. Even patients with glycosuria (which is also a late manifestation of the disease) may have a normal fasting blood sugar.

If we are to identify and treat the early diabetic, postponing and possibly preventing the onset of symptomatic diabetes, the two-hour postprandial blood sugar must be the diagnostic tool used.

Obituaries • • •

DR. CHARLES G. BOYER

One of the grand old men of New Jersey medicine—Dr. Charles George Boyer—died on June 14, 1963 at the age of 81. Born in Yorktown, Pennsylvania, in 1882, he was a graduate of the Shippensburg Teachers College. He taught in rural schools until 1907 when he entered the Jefferson Medical College of Philadelphia. After an internship in Scranton, he came to Annandale, New Jersey, in 1912—and he served the people of Hunterdon County for a half century thereafter. For all that time, he was medical inspector of Clinton Township. He had several tours of duty as president of the Hunterdon County Medical Society.

DR. WILLIAM J. BULL

Dr. William J. Bull, a retired obstetrician-gynecologist, who used to practice in Montclair, died in an upstate New York nursing home on June 13, 1963. Born in New York in 1890. Dr. Bull earned his M.D. at Flower-Fifth Avenue in 1916. He then moved to Montclair where, for almost half a century he practiced gynecology and obstetrics. He was on the staff at Mountainside Hospital, and in the 1920s and 1930s was active in committee work for the Essex County Medical Society. Dr. Bull retired in 1953.

DR. FRANK V. CILIBERTI

Dr. Frank V. Ciliberti, a prominent South Jersey practitioner, died at Cooper Hospital on July 1, 1963. Born in 1899, he was graduated in 1926 from the Jefferson Medical College. Dr. Ciliberti was a general practitioner who served the people of Camden and Gloucester Counties for 35 years. He was active in committee work with the local group of the American Association for the Advancement of Science and with the Camden County Medical Society.

DR. ISAAC GELBER

In Union Township, they used to turn the traffic light green when they saw his car coming down Stuyvesant Avenue. He was, for a quarter of a century, one of that township's favorite citizens. Officially, he was police surgeon—but unofficially, Ike Gelber, as they all called him, had a special spot in the hearts of Unionites. He was born in Europe in 1898 but came to this country at the turn of the century. The University of St. Louis granted him his M.D. in 1927 and he came to New Jersey to intern. In 1928 he opened his office in the then pastoral surroundings of Union. He was then unknown to the citizens—but not for long. He presented an extraordinary combination of meticulous, modern medical practice with the solace-giving warmth of the old fashioned family doctor.

In the 1940s he began to do more and more work in gastroenterology. He took courses and attended clinics; and then in 1946, at the age of 48, he closed his office and took a full-time course in that field at the University of Pennsylvania. He moved to Elizabeth and devoted himself full-time to gastroenterology. He became attending in that specialty at St. Elizabeth's and at Alexian Brothers and an associate gastro-enterologist at Elizabeth General. Dr. Gelber was active in civic affairs and in the work of the Union County Medical Society. He maintained to the end of his life, an active contact with the Graduate Hospital in Philadelphia and made weekly trips there for constant professional refreshment. In January 1963 he developed the symptoms of the illness that was soon to take his life. He died suddenly—and at his home—on the night of July 3, 1963. It is to such a doctor that the phrase "beloved physician" may be properly and reverently applied.

DR. PETER MANNO

At the untimely age of 52, Peter D. Manno, M.D., died in a New York hospital on June 29, 1963. A 1933 graduate of Iowa University's medical school, he interned at Christ Hospital, Jersey City, and eventually became an attending surgeon there. During World War II, he was a major in the Air Forces. He had a tour of duty as chief of surgery in the U.S.A.F. Air Base at Greenwood, Mississippi. Dr. Manno was also affiliated with the Bayonne Hospital, and with the Jersey City Medical Center. He was active in the affairs of the Hudson County Medical Society.

DR. ERIC SAVAGE

A promising medical career was prematurely snuffed out on June 15, 1963 with the death on that day of Dr. Eric D. Savage. Dr. Savage was only 47 when he died. Born in New York, he received his M.D. at Duke in 1941. He was interested in cardiology and limited his practice to internal medicine. Dr. Savage was active in civic affairs. He had served as a trustee of the Far Brook School, a vestryman of Grace Episcopal Church and chairman of the medical board of the Children's Aid Society. He was affiliated with the Hospital Center in Orange and with the Roosevelt Hospital in New York. He was president of the Essex County Heart Association in 1961. Dr. Savage was a flight surgeon during World War II. He practiced in East Orange. Death was due to a coronary attack.

Psychosomatic Profile • • •

From time to time, THE JOURNAL will publish in this space an item on psychosomatics of interest and importance to all medical practitioners. Contributions are invited and should not exceed 500 words each.

Emotions and Muscle, Bone and Joint Diseases

Common expressions in our everyday language as "weak-kneed, spineless, stiff-necked, no backbone, jittery, buck-up, get a hold of yourself, and muscle-bound" illustrate awareness of the relationships between emotions and neuromuscular, bone and joint disturbances. When such illnesses[1] are viewed as the total reaction of the patient his condition is more meaningful than the perusal of serial reports of parcellized psychic or somatic factors. Various postural and bodily attitudes often vividly reveal the underlying emotional state more than the particular appearance of any separate body part or the patient's complaints. A rigid, poised and taut stance might indicate an aggressive attitude; a limp, slouched position could suggest underlying depression. The interrelationships of structure and emotion are also illustrated by the postural concomitants of such traits as obstinacy, decisiveness, submissiveness, masculinity and femininity.

In diverse muscle, bone and joint disease states the total spectrum of psychosomatic or somatopsychic reactions can span from functional psychogenic problems to conditions like rheumatoid arthritis with discrete histopathologic changes. Observers from antiquity[2] to modern times[3] have related the onsets and exacerbations of many of these illnesses to emotional shock, worry, anxiety, fear or depression. In some instances,[4] the physiologic mediating mechanisms of these psychic factors have been studied by electromyography.[5] At times of increased emotional conflict the muscles, without active motion, show increased tension whereas during periods of relaxation there was a decrease in tension. Other studies have included the possible relationships between vascular changes[6] and arthritis and detailed psychoanalytic investigations of psychic factors in rheumatoid arthritis. Women patients' rebellion and resentment against men can actually favor the onset of arthritis. Events which increase such women's unconscious hostile, guilty feelings could precipitate attacks.

The family physician who has a detailed knowledge of his patient and the psychic constellations of other significant people in the environment is in a strategic position to observe the dynamics of various interpersonal reactions and the disease. By this understanding the physician will often receive a picture of his patient different from the facade presented to the outside world (and to himself) by the sick patient. The physician might wonder what kind of person his patient was before he developed his difficulty, what the immediate surrounding factors were when the condition developed and why the patient reacted to his symptom in the manner he did. By the use of such data, many therapeutically refractive problems might become understandable and realistically amenable to treatment. By according a consideration to the psychic aspects that is entirely commensurate to the attention given various laboratory and x-ray findings the physician can, more often, benefit his patient.

—Berthold E. Schwarz, M.D.

---

1. Rome, H.: Medical Clinics of North America, 1061 (July) 1949.
2. Paulus, A., Quoted by Thomas, G.: Am. J. Psychiatry, 93:711 (1936).
3. Lleweilyn, J., Quoted by Patterson, R., *et al.*: Am. J. Psychiatry, 99:775 (1943).
4. Gottschalk, L., *et al.*: Psychosomatic Med., 12:315 (1950).
5. Holmes, T. and Wolff, H.: Psychosomatic Med., 14:18 (1952).
6. Patterson, R. M., *et al.*: Am. J. of Psychiatry, 99:775 (1943).
7. Johnson, A., *et al.*: Psychosomatic Med., 9:295 (1947)

Book Reviews • • •

Fundamental Skills in Surgery. By Thomas F. Nealon, Jr., M.D. Philadelphia, 1962, W. B. Saunders. Illustrated by Ellen Cole. Pp. 289 ($8.50)

"Fundamental Skills in Surgery" is a practical book that outlines procedures common to all major and minor surgery. Dr. Nealon discusses the patient first: evaluating his needs, pre-operative care, preparation of the operative site, postoperative care, and management of common postoperative complications. He then describes each surgical instrument: its purpose and methods of use. The author covers sutures, suturing technics, dressing of wounds, drainage, splinting, use of plaster of paris, and so on. Anesthesia and specific applications to particular body regions are delineated.

Broadly applicable measures are then outlined for trauma, infections, and burns. Minor surgery of the skin and superficial tissues is covered, including biopsy. A special chapter reviews such common procedures as bone marrow tap, exchange transfusion, and gastric lavage. Another deals entirely with gastro-intestinal intubation and duodenal drainage. A series of chapters follows on individual body regions—with step-by-step treatment for the more usual injuries, infections, and lesions. Practical discussions on fluid and electrolyte therapy and on resuscitation round out this volume.

Detailed line drawings are interspersed throughout the book where text reference to them is made. Because of its many time-saving procedures and refinements in technics, this volume will appeal to interns, junior residents, and physicians without advanced surgical training.

STANLEY S. FIEBER, M.D.

Common Sense About Psychoanalysis. Rudolph Wittenberg, M.D., Garden City, N.Y., 1962. Doubleday. Pp. 216. ($3.95)

The public's appetite for psychiatric books should be sated by now; but the flood continues. Dr. Wittenberg here aims at correcting some misconceptions about psychoanalysis and tries to answer the more obvious questions that a layman might ask. His case studies are a bit too pat (everything works out fine), but the cases are interesting and readably presented. The lack of an index makes it impossible to use the book for serious reference work, and if a reader wants to find out about depression or the Oedipus complex, he will have to leaf through all 216 pages. Some readers will be disturbed at the author's unwillingness to give positive answers, but this is one of the occupational diseases of psychoanalysis. (For example, it appears that some patients are eager to end the analysis, others are not—a perfectly true statement, of no value to the reader.) There is a chapter hopefully called "analysis for the middle class" which tells us that 900 hours would be a possible measure for the length of an analysis; and at $20 this would cost $18,000. Since Dr. Wittenberg urges "the necessity of having weekly sessions as close together as possible," this is obviously out of reach of the economically middle classes. (The poorer patients are completely out of luck.) The author's answer is: "It would be unrealistic to attempt to propose any solution." Q.E.D.

ABRAHAM LEFF, M.D.

Shock—Pathogenesis and Therapy (An international symposium). Chairman, U. S. von Euler; edited by K. D. Bock. Goettingen, 1962, Springer-Verlag. Pp. 387 ($13.00)

Much of the presently known information about shock has been consolidated in this volume. The biologic and clinical significance of recent discoveries is revealed with suggestions for patient care.

Forty-one participants in the 1961 "shock" symposium (held in Stockholm) review their own areas of knowledge and specific interest and discuss the work of others. The material is organized well and is easily readable. The volume is useful for the reference library and for anyone interested in the large problem of shock.

ROBERT SPIRO, M.D.

Your Body: Its Anatomy and Nutrition. By C. A. Hovde, Ph.D. and S. William Kalb, M.D. Maplewood, N. J., 1962, C. S. Hammond Company. Profusely illustrated by Ronald Keller. 126 pages of text plus 18 pages of drawings plus a calorie-counter book.

The first part of this book is a simple, but correct account of human anatomy and physiology, written so that the layman can understand it. Dr. Hovde never talks down to his audience, but he doesn't patronize them either. The second section is a practical manual on nutrition, dietetics and gastrointestinal physiology. The final section is an atlas of the human body, uniquely arranged so that by cutting along pre-formed lines, the anatomic sections fall into proper relative position, one above the other. Also found here is a chart illustrating the Mendellian laws. In a pocket in the front cover is a 20-page calorie-value manual by Dr. Kalb which also includes material on salt-free diets, low cholesterol diets and height and weight tables. There is a sensible discussion on food fallacies and a brief, down-to-earth treatment of "the cholesterol story."

It used to be that we felt that a little knowledge was a dangerous thing. We frowned on medical books for the laymen. But we now realize that the layman is going to get this knowledge anyway. He is entitled to it. So he might as well get it from an authoritative source. A book like this is a real public service and practitioners can recommend it to their curious patients. Dr. Kalb is past-president of our Essex County Medical Society.

VICTOR HUBERMAN, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

SEPTEMBER, 1963 • VOL. XXXVI, NO. 7

TUBERCULIN TESTING OF SCHOOL CHILDREN

In a tuberculin testing program among elementary school children in California, a relationship was found to exist between the size of reaction and clinical disease. The Mantoux method of testing is an acceptable guide for case finding and follow up.

Because it was believed that tuberculin testing of selected age groups in elementary schools would furnish useful clues to foci of infection a testing program was undertaken in 1957 and 1958 under the joint auspices of the Tuberculosis and Health Association of California, the California State Department of Public Health, the California Conference of Local Health Officers, and the United States Public Health Service.

The intradermal Mantoux test with 5 T.U. (0.1 ml. containing .0001 of PPD-S) was used. A positive test was one with induration of 6 mm. or more. The term "Ladino" was used to identify children of Latin American or Spanish background.

Of 123,934 elementary school children enrolled in 399 schools in eleven selected areas of California, 109,152 were tuberculin tested at least once. The study group consisted of 85,751 students available for testing both years in ten areas, and of these 54,051 completed both tests.

STUDY FINDINGS

The authors' findings and conclusions from these studies were:

1. The Mantoux test, when done competently, offers a most acceptable guide for follow up and case finding. Testing errors occurred for many reasons but did not invalidate the significance of the observed conversions and reversions.

2. When the ten study areas were ranked as "high" or "low" by reported morbidity rates, the percentage of positive tests the first year followed the same general pattern as the reported morbidity rates. Positive reactions occurred in 11.1 per cent of Ladino students, in 4.5 per cent of Negroes, in 5.3 per cent of other nonwhite students, and in 2.1 per cent of the remaining white students. The positive reactors varied from 0.96 per cent at age 6 to 4.61 per cent at age 14.

3. Population density or degree of urbanization did not appear to be significantly related to incidence of tuberculin sensitivity.

4. The frequency of positive reactors and the degree of sensitivity as represented by size of reaction are related to the frequency of exposure to *Mycobacterium tuberculosis*. Rates of conversion and levels of infection in the schools paralleled incidence of active disease in the community. The rate of conversion accelerated markedly as age increased. This explains the rapid overall increase in prevalance of positives with increasing age in the 6-to-14 year age group tested. In the Ladino group, girls showed more acceleration than boys and higher levels of sensitivity at each age tested.

5. The rapid rise in conversion rates as well as of prevalence observed with increasing

HENRIK L. BLUM, M.D.; FRANK E. HESSE, M.D.; GLEN W. KENT, M.D.; and DALRIE S. LICHTENSTIGER. *The American Review of Respiratory Diseases.* February, 1963.

age at the elementary school level is best accounted for by casual exposures to older persons outside the home, the circle of such contacts enlarging with the freedom from the home environment that occurs with increasing age.

6. The frequency of reversion was inversely related to reported morbidity rates and to prevalance of tuberculin sensitivity. It occurred most frequently in the lower ages, in communities with low morbidity rates, in white students other than Ladino, and among males. Reversion also occurred most frequently among those with smaller tuberculin reactions, which were in turn most frequent among the groups with lower prevalence of tuberculin sensitivity.

7. The distribution of reaction sizes was consistent with the theory that frequency of exposure to infective doses of *M. tuberculosis* is related to the prevalence of positive skin reactors, to the frequency of conversion and clinical case morbidity rates, and that it varies inversely with frequency of reversion.

Susceptibility to clinical disease during elementary school ages (6-14 years) is no less frequent than among older persons, provided account is taken of the infected population at risk.

SMALL INDURATIONS

8. Small indurations give rise to an undue proportion of positives in a subsequent retest. This may also be true for reactions as inconsequential as "erythema only."

9. Recent converters (0-12 months) make up a significant proportion of positive reactors at ages 6 through 14.

10. Follow-up case-finding activities were recorded and the data made available to the study from two areas. In one area where 19,987 children completed at least one test, 467 index reactors on field records in 1957 yielded 1,782 contacts on follow-up. Eight new cases were found among these index reactors. Of the 1,782 contacts, 82 per cent received follow-up examinations and 17 clinically active cases were diagnosed. The 1958 follow-up examinations of 83 per cent of the 437 known or new positive reactors on field records yielded five new active cases, all new positive reactors. Of the 1,713 household and close contacts examined (83 per cent), only one new active case was found.

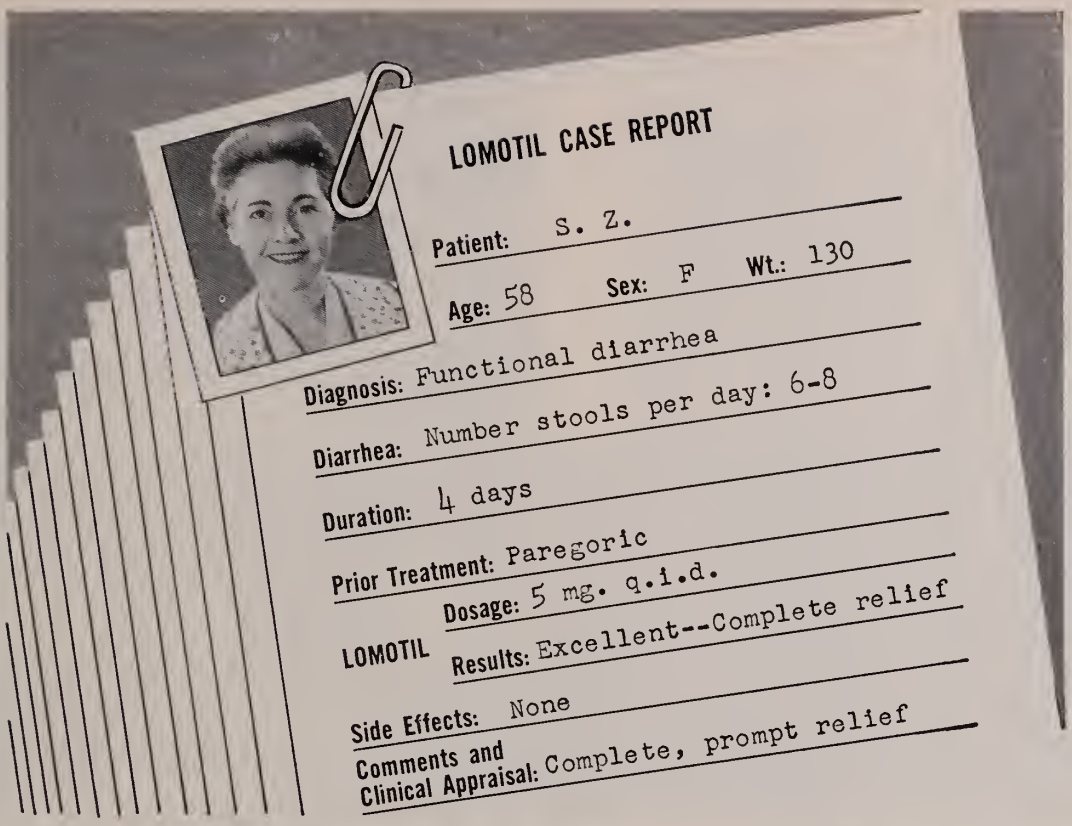
NEW CASES AND REACTORS

No cases were discovered among positive reactors or their household contacts when the index reactors had less than 9 millimeters of induration. From a case-finding standpoint, positive reactors found in the first year were more productive of new cases than were those in the second year. However, if one followed only the converters and new reactors in the second year, new active cases discovered would be of the same order of magnitude as was that of all reactors in the initial test year. The small number of cases in both years render these observations tentative.

11. The greatest number of leads to cases of tuberculosis will be found among those groups with high morbidity and high prevalence of tuberculin reactors.

12. We believe that case finding by tuberculin testing surveys would be most productive and least costly in communities having an annual tuberculosis morbidity rate of over 40, and particularly over 50 per 100,000, and in any groups having over one per cent positive reactors at age 6, three per cent at age 10, or five per cent at age 14. We expect it to be most profitable in schools having more of the higher incidence groups of children, such as ethnic and racial minorities or older ages.

NEW JERSEY TUBERCULOSIS AND HEALTH ASSOCIATION
15 EAST KINNEY STREET, NEWARK 2, NEW JERSEY



To control diarrhea . . . promptly

prescribe LOMOTIL® promptly

Each tablet and each 5 cc. of liquid contains: 2.5 mg. of diphenoxylate hydrochloride (Warning: may be habit forming) and 0.025 mg. of atropine sulfate

The direct, well-localized activity of Lomotil relieves spasm and cramping and provides prompt symptomatic control of virtually all diarrheas.

Numerous investigators have remarked on the effectiveness of Lomotil in patients with diarrhea uncontrolled by other agents.

Weingarten and his associates[1] found it "an excellent drug . . . efficacious where other drugs have failed. . . ."

Hock[2] obtained "results superior to prior medications in 68.3 per cent of 41 patients."

Since Lomotil controls diarrhea so consistently, it is only rational to prescribe Lomotil *before* other agents have a chance to prove inadequate. To control diarrhea promptly, prescribe Lomotil promptly.

Lomotil is an exempt narcotic, its abuse liability being comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. Lomotil is brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of the latter is added to discourage deliberate overdosage.

1. Weingarten, B.; Weiss, J., and Siman, M.: A Clinical Evaluation of a New Antidiarrheal Agent, Amer. J. Gastroent. 35:628-633 (June) 1961. 2. Hock, C. W.: Relief of Diarrhea with Diphenoxylate Hydrochloride (Lomotil), J. Med. Ass. Georgia 50:485-488 (Oct.) 1961.

G. D. SEARLE & CO.

Research in the Service of Medicine

FAIR OAKS HOSPITAL

SUMMIT, NEW JERSEY

CRestview 7-0143

OSCAR ROZETT, M.D.
Medical Director

MOLLIE KENNEDY, R.N.
Director, Nursing Service

EDWARD R. DUTY, M.D.
Clinical Director

N. M. JANI, M.D.
S. D. ESTRADA, M.D.
Associate Psychiatrists

THOMAS P. PROUT, JR.,
Administrator

AN 85 BED INTENSIVE TREATMENT PSYCHIATRIC UNIT

Certified by
The Joint Commission on Accreditation of Hospitals
The Central Inspection Board, American Psychiatric Assn.







"Prescribe with Confidence"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR
FOR MEN - WOMEN - CHILDREN

SOLD ON Rx ONLY
OUTFLAIR SHOES
FOR CLUB FEET

177A JEFFERSON AVE.
PASSAIC, N. J.

69 WESTWOOD AVE.
WESTWOOD, N. J.

350 MAIN ST.
HACKENSACK, N. J.

Dennis Brown Splints — in all sizes — carried in stock

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem.

KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.



KOAGAMIN®

parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenal 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

CHATHAM PHARMACEUTICALS, INC.
Newark 2, New Jersey

Distributed in Canada by Austin Laboratories, Ltd. • Paris, Ontario



Protects your angina patient better than vasodilators alone

'Miltrate' contains both pentaerythritol tetranitrate, which dilates the patient's coronary arteries, and meprobamate, which relieves his anxiety about his condition. Thus 'Miltrate' protects your angina patient better than vasodilators alone.

Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

Dosage: 1 or 2 tablets *before meals* and at bedtime. Individualization required.
Supplied: Bottles of 50 tablets.

CML-9646

Miltrate®

meprobamate 200 mg.+
pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*

ADVANCE ANNOUNCEMENT . . .

Postgraduate Courses
1963 - 1964

EDUCATION

OFFICE SURGERY
September 25 to November 20, 1963
ARTHRITIS, RHEUMATOLOGY, and ALLIED DISEASES
October 2 to December 18, 1963
DERMATOLOGY
October 3 to December 12, 1963
BASIC ELECTROCARDIOGRAPHY
October 9, 1963 to January 29, 1964
DENTISTRY
1 Day — October 23, 1963
MAMMOGRAPHY
2 Days — October 25, 26, 1963
DISEASES OF THE VASCULAR SYSTEM
February 5 to March 25, 1964
HEMATOLOGY
February 5 to April 8, 1964
ADVANCED ELECTROCARDIOGRAPHY
February 12 to April 15, 1964

ENROLL NOW!

For Information and Application, Write to—

ALBERT EINSTEIN MEDICAL CENTER
Dept. of Postgraduate Medical Education
Philadelphia 41, Pa.

TEMPLE UNIVERSITY MEDICAL CENTER

presents the 7th Annual Postgraduate Course

RECENT ADVANCES IN MEDICINE

11:00 A.M. to 4:00 P.M.
on
8 consecutive Wednesdays
from
October 16 to December 4, 1963

The course will consist of seminars, panel discussions, clinics, lectures and ward rounds considering subjects of interest to the family physician. Several distinguished out-of-state authorities will participate.

Enrollment limited. Registration fee: $50.00

FOR FURTHER INFORMATION AND CURRICULUM, WRITE TO:

Temple University Hospital, Phila. 40, Pa.
Department of Medicine

THOMAS M. DURANT, M.D.
Professor
ALBERT J. FINESTONE, M.D.
Director of Postgraduate Course

PARKWAY NURSING HOME



1201 PARKWAY AVE.
Trenton, N. J.
Tel. 882-6900

No Steps!
Ranch Type
New audio-visual call system from every patient to Nurses.

One of New Jersey's newest, most modern and completely equipped Nursing and Convalescent Homes, catering to the Convalescent, Aged, and Chronically Ill. Private and Semi-private rooms.

- Referring physician has full medical privileges
- Complete 24-hour general nursing care
- Physical rehabilitation department
- Beauty parlor. Air-conditioned dining room, lounge, and lobby. Spacious patios.
- Ultra modern interiors with artistic color scheme
- Stainless steel kitchen tiled to ceiling
- Special diets. Planned social and recreational activities
- Residential section

REASONABLE RATES — YOUR INSPECTION INVITED

PARKWAY NURSING HOME

Registration Approved by American Hospital Association
Member: Licensed Nursing Homes Assn. of N. J.
Approved to Accept Blue Cross Patients
Member: American Nursing Home Association
NEW JERSEY STATE LICENSED

LONG TERM AUTO LEASING

. . . A SERVICE ESPECIALLY PLANNED FOR DOCTORS!

M.D. PLATES FREE, TOO!

AAL LONG TERM SINGLE CAR AND FLEET RENTALS

Call ORange 6-7137 or

MAIL COUPON TODAY

Lease a brand new Cadillac or other fine car from American and you'll never **buy** again. Save money, time and trouble. One modest monthly payment takes care of everything . . . insurance, maintenance, repairs, depreciation . . . and the payments are 100% tax deductible! Borrow a car—free of charge—in case of accident or breakdown.

INCLUDES

- Registration and plates
- Full maintenance
- Insurance

Liability $250/$500,000
Property damage $20,000
Deductible collision,
fire and theft

AMERICAN AUTO LEASING COMPANY
120 Halsted St., East Orange, N. J.
Please send me the AAL Long Term Leasing Plan.

Wide Selection of '63 Models

Special requirements _____

_____

Name _____

Address _____

City _____ State _____

ALL YOU BUY IS GAS AND OIL

ASK FOR BROCHURE

AAL **AMERICAN AUTO LEASING COMPANY**

120 Halsted Street, East Orange, New Jersey • ORange 6-7137

University of Pennsylvania

Graduate School of Medicine

Announces the first in a series of short courses on

CURRENT PERSPECTIVES IN SURGERY

I. Recent Developments in the Treatment of Cancer

under the direction of

I. S. RAVDIN, M.D.
WILLIAM S. BLAKEMORE, M.D.
Department of Surgery,
Graduate School of Medicine

to be held

NOVEMBER 7, 8, and 9, 1963

Applications and detailed information may be obtained from:

OFFICE OF THE DEAN
Graduate School of Medicine
University of Pennsylvania
Philadelphia 4, Pennsylvania

NEW YORK FERTILITY INSTITUTE

For the Investigation of Problems of Human Infertility

The Institute provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

Patients are accepted by the Institute only by doctor referral and returned to the referring physician after appropriate studies have been made, together with a complete detailed report of the findings of the Institute and its consultants and recommendations for therapy. Literature on request.

123 East 89th Street, N. Y. 28, N. Y.

Phone: TR 6-9300

BRUNSWICK PARK NURSING HOME

NEW JERSEY'S NEWEST, MOST MODERN HOME FOR THE CONVALESCENT, CHRONICALLY ILL AND AGED



NOW OPEN!

NO STEPS TO CLIMB!

REASONABLE RATES

INSPECTION INVITED

- Referring physicians have full medical privileges
- Physical and recreational therapy program
- Experienced professional staff
- Special diets
- Complete 24-hour general nursing care
- Audio-Visual Nurses' call system for every bed
- Air-conditioned
- Private & semi-private rooms
- Sanitary all-stainless steel kitchen, tiled to ceiling
- Tiled wheel-in showers and baths
- Piped-In music
- Spacious outdoor patios

ON U.S. 1 AT INTERSECTION N. J. 18 (Opposite Howard Johnson's)

Tel. (201) 828-2400 Licensed by State of New Jersey **NEW BRUNSWICK, N. J.**

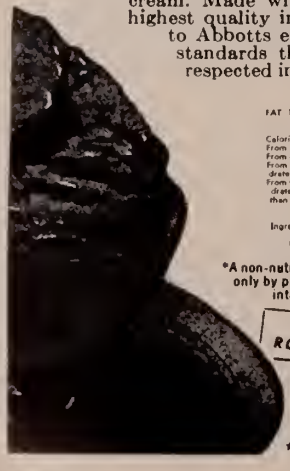
NOW! **DIABETICS CAN ENJOY**
(UNDER MEDICAL ADVICE)

Abbotts

ARTIFICIALLY SWEETENED

ICE CREAM

Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards—standards that are most highly respected in the dairy industry



COMPOSITION

FAT 10.52% PROTEIN 3.71%
CARBOHYDRATES 20.40%

	Per 100 Gm.	Oz. Avoir.	Oz. Fluid
Calories —			
From Fat	94.68	26.84	16.25
From Protein	14.84	4.21	2.55
From Carbohydrates as Lactose	20.24	5.74	3.47
From Carbohydrates other than Lactose	61.66	17.48	10.58
	191.42	54.27	32.85

Ingredients: Cream, Milk, Sorbetol, Stabilizer and 0.11% Cyclamate Calcium*

*A non-nutritive artificial sweetener for use only by persons who must restrict their intake of ordinary sweets.

IN HANDY ROUND PINTS

At Abbotts and Jane Logan Dealers
Abbotts Dairies

DUGAN'S

"Bakers for the Home"

New - LITE DIET BREAD

(White Bread Baked Without Shortening)
Calories per Slice 42 Calories per oz. 70

ALSO

SALT-FREE BREAD
GLUTEN AND PROTEIN BREADS
100% WHOLE WHEAT
100% Whole Wheat Crackers

New York New Jersey
Connecticut Pennsylvania

"At Your Door or To Your Store
It's DUGAN'S for BETTER Baked Goods"

Phone for Delivery

HUmboldt 2-6007 in Newark

(or your local phone book for branch nearest you)

DORETHY-HALL SCHOOL

Established 1909

A refined home school for exceptional girls. Limited to eight pupils. Individual care and instruction.

For booklet address:
Miss Mary E. Dorethy, *Director*

BELMAR **NEW JERSEY**

The Standard of Quality for Over Thirty Years

MILLSIDE FARMS

Distributors of
Milk and Milk Products
for the Home and Store

U. S. Route 130
RIVERSIDE, N. J.

Visit our Modern Dairy Barn

HObart 1-0046

GREENLEAF FUNERAL HOME

108 West Palisade Avenue

ENGLEWOOD, N. J.

LO 8-0416 Est. 1893

The Morristown Rehabilitation Center

66 MORRIS STREET **MORRISTOWN, NEW JERSEY**

JEFFERSON 9-3000



NATHAN KAPLAN, M.D., Physiatrist
MARY E. JOHNSON, Chief Therapist

ANN G. McMANUS, R.N.
Director of Nursing Service

AUDREY E. TAHLMORE
Administrator

A 38-bed rehabilitation unit specializing in orthopedic and neurological disabilities. Speech therapy, Occupational therapy and psychological evaluation available.

- - - - - -

AMERICAN HOSPITAL ASSOCIATION ACCREDITATION
MEMBER NEW JERSEY LICENSED NURSING HOME ASSOCIATION



The FIRST Hematinic to Contain BOTH CHELATED IRON and CHELATED MINERALS Assuring a Truly Flavorful, Better Tolerated Iron Therapy.

ADVANTAGES —
Chelated Iron PLUS 4 Chelated Minerals • High Therapeutic Effectiveness • Less Irritation — even on empty stomach • No Tooth Stain • Less Toxic • B-Vitamins for Added Hemopoietic Activity • Pleasant Flavor • Economical

KELATRATE
LIQUID HEMATINIC
CHELATED IRON-MINERALS and VITAMINS

FORMULA —
Each 5 cc. (one teaspoonful) contains:

Iron (as Ferrous Betaine Citrate)	30 mg.
Cobalt (as Cobaltous Betaine Citrate)	0.1 mg.
Manganese (as Manganese Betaine Citrate)	1.0 mg.
Zinc (as Zinc Betaine Citrate)	1.25 mg.
Magnesium (as Magnesium Betaine Citrate)	6.0 mg.
Vitamin B-1	1.5 mg.
Vitamin B-2	1.2 mg.
Vitamin B-12	6.0 mcg.
Niacinamide	10 mg.
Panthenol	10 mg.

In an exceptionally pleasant tasting base.

Comprehensive literature and samples on request.

S. J. TUTAG & CO.
DETROIT 34, MICHIGAN

TUTAG

Office Suites Available - New Medical Building
Kinnelon, New Jersey

Area in need of general practitioner, surgeon, obstetrician, pediatrician, dentist.

HENRY D. RICKER, Broker **BUTLER, NEW JERSEY — TE 8-0400**

Raymond A. Lanterman & Son

Exclusive Funeral Service

126 SOUTH STREET MORRISTOWN, N. J.

PHONE JE 9-2880

R. A. Lanterman Wm. V. D. Lanterman

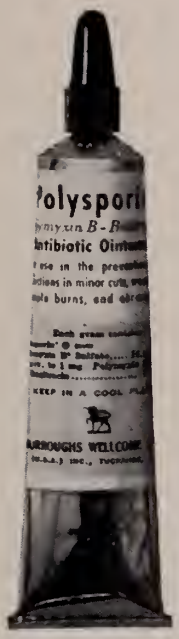
Estate Security Corporation • Legatees Funding Corporation

L. JOSHUA WEINER, President

Estate, Corporate Analysts Investment Advisors
Professional and Business Management Consultants

1180 Raymond Boulevard **Newark 2, New Jersey**
Area Code 201 **MArket 2-6620-21**

in treating topical infections, no need to sensitize the patient



USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN ANTIBIOTIC OINTMENT

broad-spectrum antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **Supplied:** in ½ oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

How Lyons Institute Serves the Medical Profession

For the past eleven years Lyons Institute of Medical, Dental and X-ray Technology has been training high school graduates to serve the medical profession as:

MEDICAL TECHNOLOGIST • MEDICAL TECHNICIAN • MEDICAL ASSISTANT
X-RAY TECHNICIAN • MEDICAL SECRETARY

Many hundreds of our graduates are employed by physicians, hospitals, clinics, laboratories, pharmaceutical concerns and private industry. If you are seeking qualified personnel in any one of the above fields, our free Placement Bureau is at your Service.

LYONS INSTITUTE of MEDICAL, DENTAL & X-RAY TECHNOLOGY
900 BROAD STREET, NEWARK 2, N. J. **Telephone: MItchell 2-3420**
Director, CRAIG R. GARTH, Captain, U.S. Navy (Ret.)
Approved by the New Jersey State Department of Education

RADON • RADIUM

SEEDS • IMPLANTERS • CERVICAL APPLICATORS

THE RADIUM EMANATION CORPORATION

GRAYBAR BUILDING • NEW YORK 17, N. Y.
Wire or Phone MUrray Hill 3-8636 Collect

COUNTY SOCIETY PRESIDENTS AND SECRETARIES

1963 — 1964

County	President	Secretary
Atlantic	John W. Holland, M.D., Margate City	David B. Scanlan, M.D., Ventnor
Bergen	Samuel B. Reich, M.D., Hackensack	Charles P. Campbell, M.D., Hackensack
Burlington	Keith R. Young, M.D., Burlington	Amy S. Barton, M.D., Medford Lakes
Camden	James R. Eynon, M.D., Cherry Hill	Frederick W. Durham, M.D., Haddonfield
Cape May	Carl J. Records, M.D., Cape May	Francis X. Farrell, M.D., Cape May
Cumberland	Peter Penico, M.D., Millville	Frank J. T. Aiken, M.D., Bridgeton
Essex	Joseph P. Klenk, M.D., East Orange	Raphael E. Remondelli, M.D., East Orange
Gloucester	Harry B. Lochhead, M.D., Woodbury	Robert B. Hutcheson, M.D., Woodbury
Hudson	Clement M. Jones, M.D., Bayonne	Charles L. Cunniff, M.D., Jersey City
Hunterdon	Edwin V. Olmstead, M.D., Flemington	John B. Fuhrmann, M.D., Flemington
Mercer	Henry L. Drezner, M.D., Trenton	James B. Goyne, M.D., Trenton
Middlesex	Rudolph G. Matfield, M.D., New Brunswick	Charles Di Liberti, M.D., Princeton
Monmouth	Frank Niemtzow, M.D., Freehold	Anthony L. Rifici, M.D., Asbury Park
Morris	Adolph R. Wichman, M.D., Denville	Morris Dirdack, M.D., Morristown
Ocean	Jesse Schulman, M.D., Lakewood	Walter E. Corrigan, M.D., Toms River
Passaic	Marion F. Kaletkowski, M.D., Paterson	Irving Chrisman, M.D., Paterson
Salem	Philip K. Boyer, M.D., Woodstown	George F. Reichwein, M.D., Penns Grove
Somerset	Ernest R. Gentile, M.D., Somerville	Alfred S. Conston, M.D., Somerville
Sussex	Robert A. Weinstein, M.D., Newton	David H. Welsh, M.D., Newton
Union	Joseph M. Gannon, M.D., Elizabeth	Roy T. Forsberg, M.D., Elizabeth
Warren	James H. Spillane, M.D., Phillipsburg	Ralph M. L. Buchanan, Phillipsburg

Flavoring Improves Palatability of Acidophilus Milk

In the treatment of acne vulgaris and such gastro-intestinal disorders as simple chronic constipation and simple diarrhea, patient resistance to ingestion of Acidophilus may be controlled if flavor is improved by stirring 1 to 2 teaspoons of Jell-O powder into each glass of Acidophilus Milk before serving. Most popular flavors are raspberry, cherry, orange-pineapple, blackberry, and strawberry. For patients on low-calorie diets, substitute D-Zerta for Jell-O. Add a few drops of Sweeta or Sweet-10 to the flavored Acidophilus for a sweeter drink.

WALKER-GORDON ACIDOPHILUS

2% butterfat, made from Walker-Gordon Certified Milk cultured with 300-500 million acidophilus bacilli per ml. Available through leading milk dealers.

WALKER-GORDON CERTIFIED MILK FARM, Plainsboro, N. J.

SWinburne 9-1234 (N. Y. WAlker 5-7300; Phila. PEnnypacker 5-3465)

CLASSIFIED ADVERTISEMENTS

Send replies to box number, c/o THE JOURNAL
P. O. Box 904, Trenton 5, New Jersey

$5 for 25 words or less; additional words 10c each
Payable in advance of publication

Forms close 15th of the preceding month.

INTERNIST—33, board qualified, specialty training in cardiology and chest medicine. Seeks association with internist, group or other position. New Jersey license. Write Box No. 71, c/o THE JOURNAL.

YOUNG INTERNIST—Age 31. Desires junior partnership or assistantship. Wishes to locate in New Jersey. Write c/o Maurice LeDrappier, 38 Montrose Avenue, Summit, New Jersey.

HOSPITAL ADMINISTRATION—Retired medical service corps officer desires position of responsibility in office administration or hospital supply and procurement. Wide variety of experience in Army hospital administration for 15 years. Also 8 years' experience as liaison representative for the Surgeon General, Department of Army, in hospital construction. College education. Age 41. Resume and references furnished upon request. Write to William O. Rhoda, Major, Ret., 132 Rogers Street, Aberdeen, Maryland; or phone Code 301-272-3553.

ASSOCIATE WANTED—Established general practice centrally located Camden, New Jersey, suburb. Option to buy or establish specialty. Room for expansion or rental of remainder of building. Write Box No. 72, c/o THE JOURNAL.

IRVINGTON—600 square foot suite remaining in new professional building, presently occupied by dentist, allergist, optometrist, and speech therapist. 1146 Stuyvesant Avenue. ES 3-1073, MU 6-0787.

FOR RENT—In North Bergen area, share active general practitioner's large ten room office. All facilities provided; large parking area near all transportation. Medical specialist desired. Write Box No. 73, c/o THE JOURNAL.

FOR SALE—Home-office combination. Eighteen miles from Camden-Philadelphia bridge. Established general practice grossing $45,000. Reply c/o THE JOURNAL, Box 74.

MEDICAL ARTS BUILDING—Tenafly, Corner County Road & Central Avenue. Immediate occupancy. Modeled to suit your needs without extra charge. All maintenance services included. Elevator. Central air-conditioning. Covered on-site parking. Convenient to hospitals. 24 hour service. Call—Day: DE 3-7700; Eves.: (NY) MA 1-4035.

FOR SALE—Home-office-practice for sale. Large, active, all-year-around. Near seashore resorts. South New Jersey. Long established. Liberal terms. Retiring. Send replies to P.O. Box 75, c/o THE JOURNAL.

GENERAL PRACTICE FOR SALE—Well-established active general practice with large growth potential by comparatively young doctor. Ideal highest income area Bergen County, New Jersey. Convenient to NYC. Suitable for internist or group. Open staff hospital nearby. Attractive modern air-conditioned, centrally located building designed for professional use. Full introductions. Attractive price. Rental includes full use of furnishings and equipment at no additional cost. Terms can be arranged. Family estate plans demand full time of seller. Complete details available. Professional Management Associates, Box 52, East Paterson, New Jersey.

WHO PAYS THE OFFICE RENT?

And telephone bill...and utilities...and employee salaries...*if YOU are sick or injured?*

Physicians Mutual Insurance Company (The Doctors' Company) will help pay all of your usual office expenses when you are sick or disabled—if you are the fortunate owner of our new, low-rate Office Overhead Expense Policy.

Premiums are tax deductible, too!

Write today for free information . . without obligation.

PHYSICIANS MUTUAL INSURANCE COMPANY
115 South 42nd St. Omaha 31, Nebraska



whatever the shape or form of allergy...

Benadryl®

(Diphenhydramine hydrochloride)

effectively relieves the symptoms of vasomot rhinitis For patients sensitive to animal danders, this age provides twofold therapeutic action to help abort an allerg attack. **Antihistaminic action:** A potent antihistaminic breaks the cycle of allergic response, bringing relief of snee



ing, lacrimation, nasal blockage, and rhinorrhea. **Antispasmodic action:** Because of its inherent atropine-like properties, the drug affords concurrent relief of bronchial spasm. ***Indications:*** Allergic diseases such as hay fever, allergic rhinitis, urticaria, angioedema, bronchial asthma, serum sickness, atopic dermatitis, contact dermatitis, gastrointestinal allergy, vasomotor rhinitis, pruritus, physical allergies, reactions to injection of contrast media, reactions to therapeutic preparations, and allergic transfusion reactions; also postoperative nausea and vomiting, nausea of pregnancy, motion sickness, parkinsonism and drug-induced extrapyramidal reactions, and quieting emotionally disturbed children. Parenteral administration is indicated where, in the judgment of the physician, prompt action is necessary and oral therapy would be inadequate. ***Precautions:*** Avoid subcutaneous or perivascular injection. Single parenteral dosage greater than 100 mg. should be avoided, particularly in hypertension and cardiac disease. Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers, if used with this product, should be prescribed with caution because of possible additive effect. Diphenhydramine hydrochloride has an atropine-like action which should be considered when prescribing it. Cream (Ointment) should not be applied to extensively denuded or weeping skin areas. ***Supplied:*** Kapseals® of 50 mg.; Capsules of 25 mg.; Emplets® (enteric-coated tablets) of 50 mg.; in aqueous solutions: 1-cc. Ampoules, 50 mg. per cc.; 10- and 30-cc. Steri-Vials,® 10 mg. per cc. with 1:10,000 benzethonium chloride as a germicidal agent; Elixir, 10 mg. per 4 cc. with 14 per cent alcohol; 2 per cent Ointment (water-miscible base).

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan

14563

ROCHE

specific
for
anxiety
and
tension

LIBRIUM®
(chlordiazepoxide HCl)
ROCHE®

Dosage: Oral—Usual adult dose in mild to moderate anxiety and tension is 5 or 10 mg, 3 or 4 times daily; in severe anxiety and tension, 20 or 25 mg, 3 or 4 times daily. Side Effects: Oral—Drowsiness and ataxia, usually dose-related, have been reported in some patients—particularly the elderly and debilitated. Paradoxical reactions, *i.e.*, excitement, stimulation, elevation of affect and acute rage, have been reported in psychiatric patients; these reactions may be secondary to relief of anxiety and should be watched for in the early stages of therapy. Other side effects, usually dose-related, have included isolated instances of minor skin rashes, minor menstrual irregularities, nausea, constipation, increased and decreased libido. Precautions: Oral—In elderly, debilitated patients, limit dosage to smallest effective amount to preclude development of ataxia or oversedation (not more than 10 mg per day initially, to be increased gradually as needed and tolerated). Until the correct maintenance dosage is established, patients receiving this agent should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Caution patients about possible combined effects with alcohol. Caution should be exercised in administering Librium (chlordiazepoxide HCl) to addiction-prone individuals. Careful consideration should be given to the pharmacology of any agents to be employed concomitantly—particularly the MAO inhibitors and phenothiazines. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests may be advisable in protracted treatment. Caution should be exercised in prescribing any therapeutic agent to pregnant patients.

THE Journal OF

THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since 1904
Copyright 1963 by The Medical Society of New Jersey

Entered as second-class matter Sept. 5, 1906, at the post office, Orange, N. J., under Act of March 3, 1879
Second-Class Postage Paid at Orange, N. J.

VOL. 60, NO. 10 OCTOBER, 1963 50 Cents - $5.00 PER YEAR

THE N.Y. ACADEMY OF MEDICINE
OCT 25 1963
LIBRARY

CONTENTS—pages 457 to 496

EDITORIALS— Page

Are Participating Physicians Really Participating? 457
Seton Hall Respiratory Project 458
The Idea Behind the Word 458

ORIGINAL ARTICLES—

Hospital Costs—Frank K. Kent, Trenton 459

Orchitis and Coxsackie Virus Infection—Albert Minzter, M.D., Elizabeth 463

Therapy Through Music and the Arts—Myrtle Fish Thompson, B.A., Cedar Grove 467

Pregnancy in Cushing's Syndrome—Jerome Abrams, M.D., and Frank C. Dresdale, M.D., Plainfield; Elmer C. Bartels, M.D., Boston, Mass. 474

Multiple Vitamins Containing Folic Acid—William F. Haynes, Jr., M.D., Princeton 477

ORIGINAL ARTICLES— Page

Resection of Perforated Colonic Lesions—Robert J. Ryan, M.D., Trenton 480

Gastric Cooling—Theodore S. Heineken, M.D., Glen Ridge 482

Lung Function Testing in the Office—Burton M. Cohen, M.D., Elizabeth 484

LETTER TO THE JOURNAL 488
PSYCHOSOMATIC PROFILE 489

STATE ACTIVITIES—
Trustees' Meeting: July 21, 1963 490

ANNOUNCEMENTS 492
OBITUARIES 493
BOOK REVIEWS 494
RESPIRATORY DISEASE ABSTRACTS 495

Roster of Officers, 3 A

NOVEMBER

IS

LIFE MONTH

FOR

THE MEDICAL SOCIETY OF NEW JERSEY

LIFE INSURANCE PLAN

From $10,000 to $50,000

Term Life Insurance

INCLUDING

- **Waiver of Premium Benefit**
- **Accidental Death Benefit**
- **Conversion privilege**
- **Dividends as declared by company**

LIFE MONTH ENDS NOVEMBER 30th . . . YOUR NEXT CHANCE TO APPLY WILL BE NOVEMBER, 1964

For information and assistance call

E. & W. Blanksteen Agency, Inc.

75 Montgomery Street **Jersey City, New Jersey 07302**

DElaware 3-4340

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATON, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.
EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154
(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

OFFICERS

President, Jerome G. Kaufman, M.D. ..... Maplewood
President-Elect, Charles H. Calvin, M.D. ..... Perth Amboy
First Vice-President, John J. Bedrick, M.D. .....Bayonne
Second Vice-President, Joseph R. Jehl, M.D. ..... Clifton
Secretary, Marcus H. Greifinger, M.D. .....Newark
Treasurer, Daniel F. Featherston, M.D. ..... Asbury Park

Richard I. Nevin, *Executive Director* ..... Trenton
Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton

TRUSTEES

Samuel J. Lloyd, M.D., *Chairman* (1966) ..... Trenton
Nicholas A. Bertha, M.D., *Secretary* (1965) ..... Wharton
Jerome G. Kaufman, M.D. ..... Maplewood
Charles H. Calvin, M.D. ..... Perth Amboy
John J. Bedrick, M.D. ..... Bayonne
Joseph R. Jehl, M.D. ..... Clifton
Marcus H. Greifinger, M.D. ..... Newark
Daniel F. Featherston, M.D. ..... Asbury Park
Louis S. Wegryn, M.D. ..... Elizabeth
Louis F. Albright, M.D. (1964) ..... Spring Lake
Louis K. Collins, M.D. (1964) ..... Glassboro
Thomas C. DeCecio, M.D. (1965) ..... Cliffside Park
Joseph P. Donnelly, M.D. (1966) ..... Jersey City
Lloyd A. Hamilton, M.D. (1965) ..... Lambertville
Frank J. Hughes, M.D. (1966) ..... Gloucester
John F. Kustrup, M.D. (1966) ..... Trenton
Emanuel M. Satulsky, M.D. (1964) ..... Elizabeth
Carl N. Ware, M.D. (1965) ..... Ocean City

COUNCILORS

First District (Essex, Morris, Union, and Warren Counties) ..... Thomas S. P. Fitch, M.D., Plainfield (1966)
Second District (Bergen, Hudson, Passaic, and Sussex Counties) ..... John L. Olpp, M.D., Englewood (1965)
Third District (Hunterdon, Mercer, Middlesex, and Somerset Counties) ..... Albert F. Moriconi, M.D., Trenton (1964)
Fourth District (Burlington, Camden, Monmouth, and Ocean Counties) ..... E. Vernon Davis, M.D., Moorestown (1966)
Fifth District (Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties) .... Isaac N. Patterson, M.D., Westville (1965)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell, M.D. (1964) ..... Asbury Park
William F. Costello, M.D. (1963) ..... Dover
Joseph P. Donnelly, M.D. (1965) ..... Jersey City
Marcus H. Greifinger, M.D. (1964) ..... Newark
Luke A. Mulligan, M.D. (1964) ..... Leonia
Isaac N. Patterson, M.D. (1965) ..... Westville

Alternates

F. Clyde Bowers, M.D. (1964) ..... Mendham
Frank J. Hughes, M.D. (1964) ..... Gloucester
Joseph R. Jehl, M.D. (1965) ..... Clifton
John F. Kustrup, M.D. (1964) ..... Trenton
Elton W. Lance, M.D. (1965) ..... Rahway
John L. Olpp, M.D. (1963) ..... Englewood

DELEGATES TO OTHER STATES

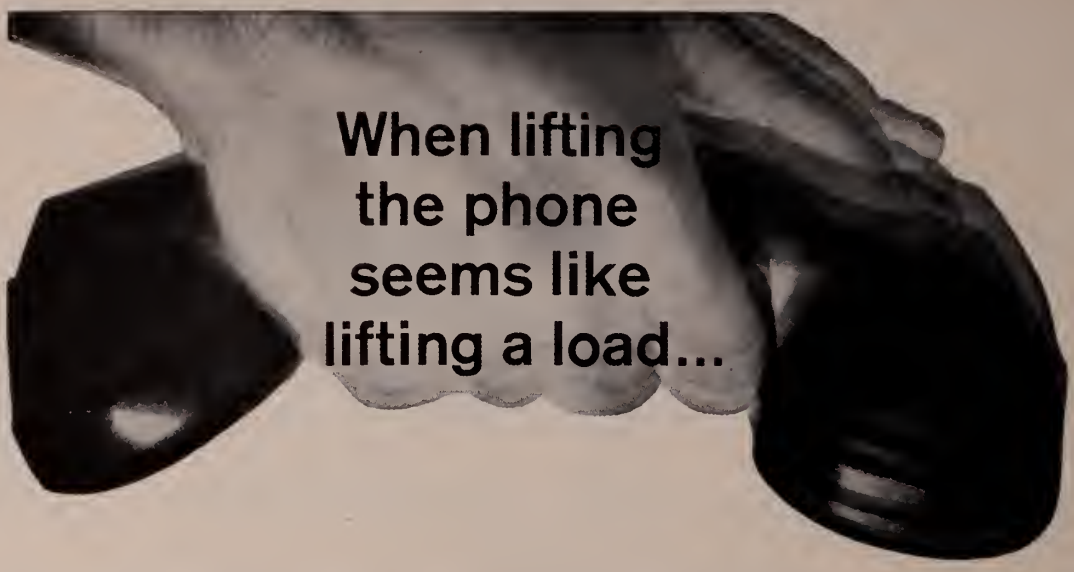
New York—William F. Costello, M.D. (1963) ..... Dover
Connecticut—Lloyd A. Hamilton, M.D. (1963) .. Lambertville
New York—G. Ruffin Stamps, M.D. (1963) .... Atlantic City
Connecticut—S. Eugene Dalton, M.D. (1963) ..... Ventnor

Scientific Exhibits — 1964 Annual Meeting

Members are invited by the Committee on Annual Meeting and its Subcommittee on Scientific Exhibits to present scientific exhibits at the 198th Annual Meeting next May in Atlantic City. The exhibits will run from 9:00 a. m. on Monday, May 18, to 3:00 p. m. on Wednesday, May 20, 1964.

The Subcommittee will accept applications up to, and including, December 16, 1963, following which the scientific exhibits will be selected.

Applications may be obtained from the Executive Offices of MSNJ, P. O. Box 904, Trenton, New Jersey 08605. Write for yours now.



in chronic bronchitis and emphysema

ISUPREL® hydrochloride BRAND OF ISOPROTERENOL hydrochloride

MISTOMETER® Q.I.D.

ISUPREL (isoproterenol/Winthrop) "...can increase breathing efficiency in pulmonary emphysema."[1] The patient with chronic obstructive pulmonary disease "...should use the bronchodilator four times daily whether or not he experiences episodes of bronchospasm."[2]

Use of the Mistometer eases breathing by relaxing bronchospasm, and aiding productive cough. "Of the aerosol bronchodilators, ISUPREL (isoproterenol/Winthrop) seems to be the best...."[3] Conscientious use q.i.d. improves vital capacity and exercise tolerance.

The Mistometer brings new efficacy and convenience—enables patients to maintain treatment wherever they are.

With use of ISUPREL (isoproterenol/Winthrop), occasionally tachycardia, palpitation, nervousness, nausea and vomiting or headache may occur, especially with excessive dosage. Adjust dosage carefully in patients with hyperthyroidism, acute coronary disease, cardiac asthma or limited cardiac reserve, and in persons sensitive to sympathomimetic amines.

Caution: Epinephrine should not be administered with ISUPREL (isoproterenol/Winthrop) as both drugs are direct cardiac stimulants and their combined effects may induce serious arrhythmia. If desired they may, however, be alternated, provided an interval of at least four hours has elapsed.

Dosage: Two inhalations at least one minute apart four times daily, regularly. Inhalations may be taken more often if indicated.

Available as ISUPREL HCl (isoproterenol HCl/Winthrop) Mistometer—single unit combining plastic nebulizer and ISUPREL (isoproterenol/Winthrop) solution 1:400—or 0.25 per cent w/w (=2.8 mg. per ml.), and includes alcohol, 33 per cent; bottles of 15 ml.



1. Reeves, J. E.: *M. Times* 90:512, May, 1962. 2. Williams, M. H., Jr.: *M. Sc.* 11: 433, March 19, 1962. 3. Peckenschneider, L. E.: *J. Kansas M. Soc.* 56:486, Sept., 1955.

Winthrop Laboratories, New York 18, N.Y.

Winthrop



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and
a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain...not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

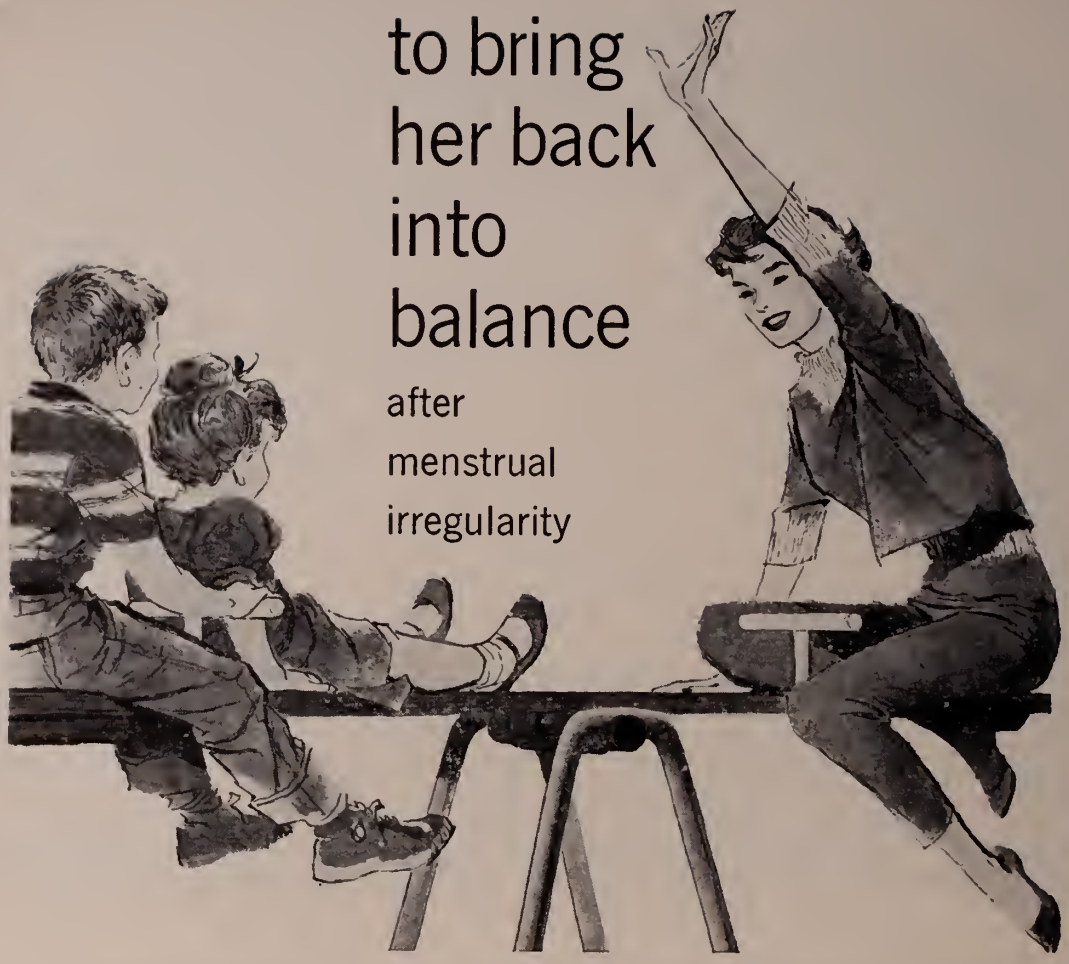
Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

®WALLACE LABORATORIES / *Cranbury, N.J.*

to bring her back into balance

after menstrual irregularity



an orally active progestogen-estrogen combination

Duosterone®

Ethisterone . . . 10.00 mg. Ethinyl estradiol . . . 0.01 mg. per tablet

Supplementing and supporting ovarian function, DUOSTERONE can help release your patients from the anxiety, discomfort and inconvenience of functional amenorrhea, dysmenorrhea, and dysfunctional uterine bleeding.

Periodic progestational treatment with DUOSTERONE aims at restoring the normal hormonal pattern of the secretory phase of the menstrual cycle, providing an orally active progestogen with an estrogen to prime the endometrium for adequate progestational response.

Dosage: Functional amenorrhea, 5 tablets daily for 5 days. Dysmenorrhea, 1 to 2 tablets daily during the second half of the menstrual cycle, except for the final two days. Dysfunctional uterine bleeding, 5 to 7 tablets daily for 5 days; in mild cases, reduce dose 1 tablet each day.

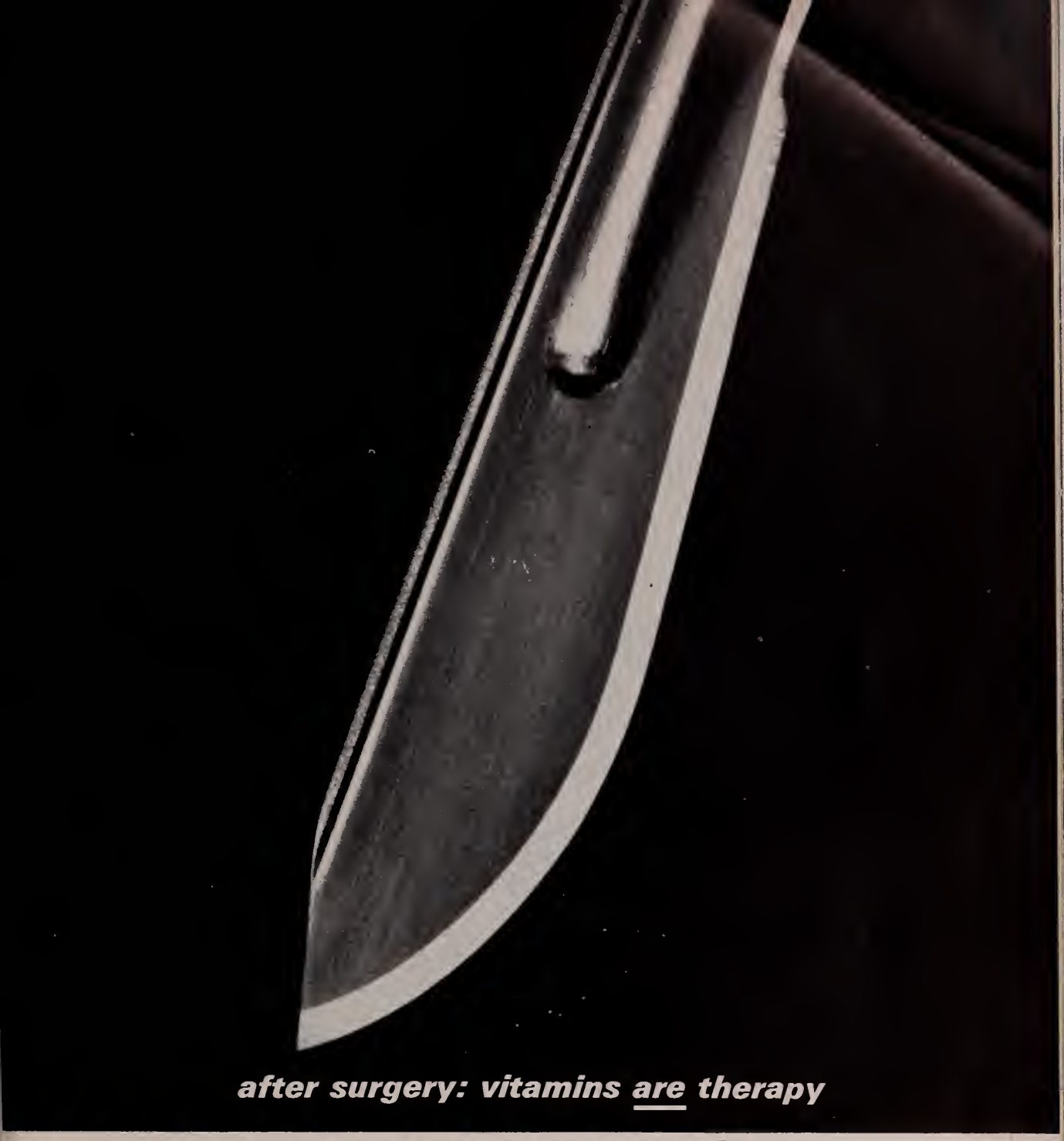
Side Effects: Ethinyl estradiol may occasionally cause headache, diarrhea, engorgement and tenderness of the breasts, nausea, vomiting, cramping, or skin rash. These side effects usually fade as the patient adjusts to the estrogen.

Cautions and Contraindications: DUOSTERONE is contraindicated in carcinoma of the breast and reproductive organs and should be used with caution in cases of known liver impairment.

Supplied: Bottles of 25 and 100 tablets.

ROUSSEL

Roussel Corporation
155 East 44th Street, New York 17, N.Y.



after surgery: vitamins are therapy

Nutritional supplementation is basic to postoperative care. Therapeutic allowances of B and C vitamins help meet increased metabolic requirements and compensate for stress depletion. STRESSCAPS can set the patient on a more favorable course and contribute to full recovery.

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains: Vitamin B_1 (Thiamine Mononitrate)...10 mg. / Vitamin B_2 (Riboflavin)...10 mg. / Niacinamide... 100 mg. / Vitamin C (Ascorbic Acid)...300 mg. / Vitamin B_6 (Pyridoxine HCl)...2 mg. / Vitamin B_{12} Crystalline... 4 mcgm. / Calcium Pantothenate...20 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

6316-3

STRESSCAPS®

Stress Formula Vitamins Lederle

neither **tension,** nor **spasm,**
nor **stasis**
stays this patient
from his
appointed rounds



DECHOLIN-BB®

. . . . . especially when
UPPER G.I. COMPLAINTS
have biliary implications

for nervous **tension** → **Each Tablet Contains:** BUTABARBITAL SODIUM 15 mg (¼ gr.).
WARNING: May be habit forming

for smooth-muscle **spasm** → BELLADONNA EXTRACT 10 mg. (⅙ gr.).

for biliary/intestinal **stasis** → DEHYDROCHOLIC ACID 250 mg. (3¾ gr.).

Average adult dose: 1 or, if necessary, 2 tablets three times daily. **Precautions:** Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction; caution drivers against possible drowsiness. **Side effects:** Dehydrocholic acid may cause transitory diarrhea; belladonna may cause blurred vision and dry mouth. **Contraindications:** Biliary tract obstruction, acute hepatitis, glaucoma, prostatic hypertrophy. **Available:** DECHOLIN-BB, bottles of 100 tablets. **Also:** DECHOLIN® with Belladonna (dehydrocholic acid, 250 mg.; belladonna extract, 10 mg.) and DECHOLIN® (dehydrocholic acid, 250 mg.), bottles of 100 and 500 tablets.

AMES COMPANY, INC

546R243

Important news in cardiac therapy

Two new clinical reports document successful long-term treatment of ischemic heart disease with Persantin,® brand of dipyridamole

See next 3 pages

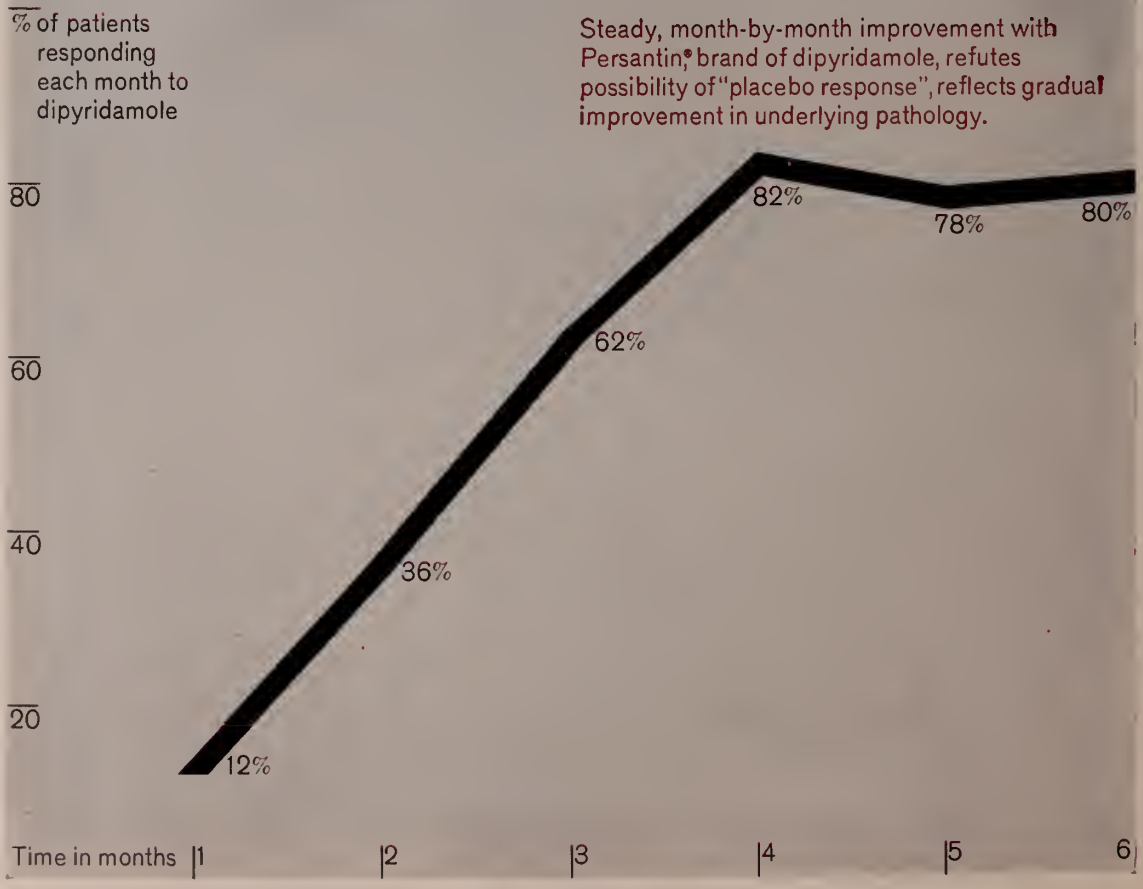
Study 1.
Griep,A.H.: Long-term Therapy of Ischemic Heart Disease With Oral Dipyridamole:
A Report of Fifty Cases. Angiology 14:484, 1963.

Persantin,® brand of dipyridamole, 25 mg. t.i.d. or q.i.d.,was administered continuously for 6 months to 50 patients with well authenticated ischemic heart disease with angina pectoris and ECG abnormalities. Results were evaluated on a monthly basis; final evaluation after 6 months showed that 56% of patients were completely free of, or had markedly fewer, anginal attacks, with normal or improved ECG findings; an additional 24% experienced fewer, milder attacks and improved work capacity.

Persantin®
brand of dipyridamole

"...long-term oral therapy with dipyridamole was of benefit in 80 per cent of the patients... relief [of angina] came slowly and was usually maximal after three to six months of continuous treatment"

Steady, month-by-month improvement with Persantin,® brand of dipyridamole, refutes possibility of "placebo response", reflects gradual improvement in underlying pathology.



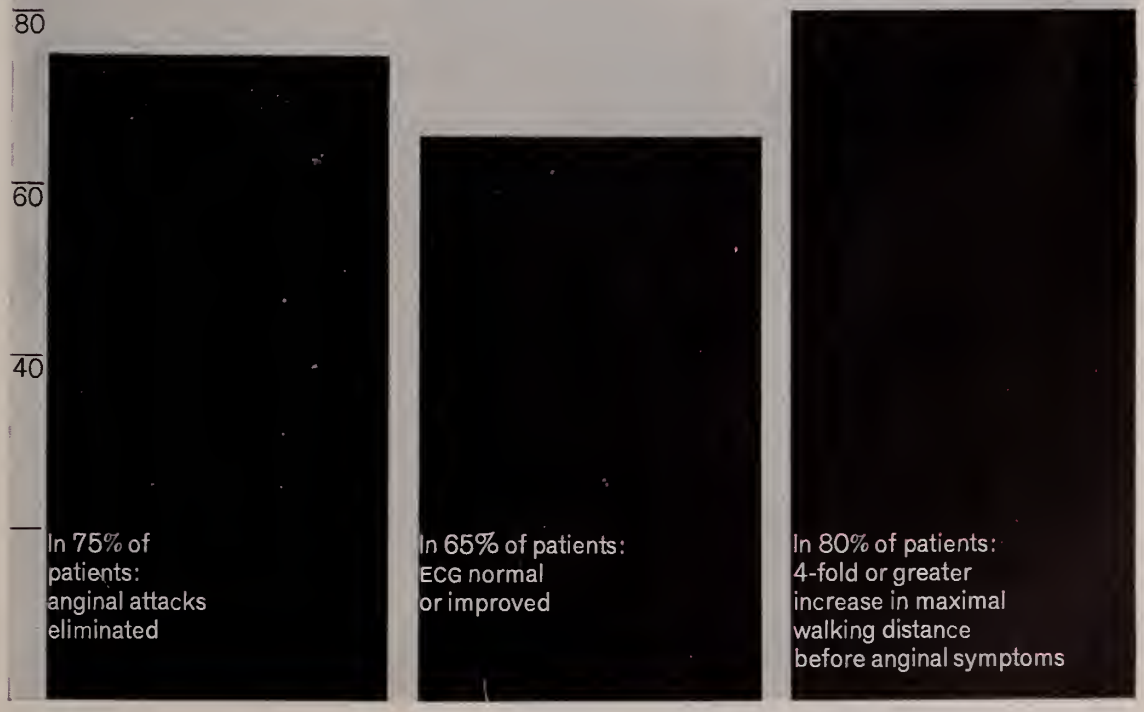
Study 2.
Wirecki,M.: Dipyridamole (Persantin®): Evaluation of Long-Term Therapy in Angina Pectoris. Current Therapeutic Research 5:472, 1963.

In 40 ambulatory patients with myocardial ischemia, angina pectoris, and abnormal ECG findings, Persantin,® brand of dipyridamole, 25 mg. t.i.d., was administered continuously for 3 months.

Results after 3 months of therapy revealed a satisfactory clinical response in 32 patients. The accompanying diagram illustrates the specific criteria of improvement in patients with excellent or good response.

Of 40 patients, 32 showed "...reduction or abolition of acute anginal attacks...complete or almost complete disappearance of ECG abnormalities... marked increase" in walking distance without anginal symptoms

Response after 3 months of continuous therapy with Persantin,® brand of dipyridamole



How Persantin,® brand of dipyridamole, provides long-term clinical benefits reported on previous pages

1. By increasing energy yield
of the hypoxic myocardial cell, by direct action upon the sarcosomes (heart mitochondria).[1-5]

2. By improving collateral coronary circulation.
Prolonged oral administration of dipyridamole to animals with experimentally induced stenosis of a major coronary artery resulted in superior development of collateral coronary anastomoses and longer survival compared with controls.[6-9]

When given for prolonged periods and in adequate dosage, dipyridamole improves the coronary flow deficit of the ischemic myocardium while supporting cardiac metabolism during the period of repair. Clinically, this is manifested as steady improvement – anginal attacks diminish in frequency and intensity, as do other manifestations of insufficiency (dyspnea, fatigue, and, in many instances, abnormal electrocardiographic findings).

Availability:
Tablets of 25 mg., bottles of 100 and 1000.
Under license from Boehringer Ingelheim G.m.b.H.

Prescribing summary: Persantin,® brand of dipyridamole, is indicated in coronary and myocardial insufficiency, in a dosage of 2 to 6 tablets daily in divided doses before meals for several weeks. Side effects (headache, dizziness, nausea, flushing, weakness, syncope, mild gastrointestinal distress) are minimal and transient. The drug is not recommended in the acute phase of myocardial infarction, and should be used cautiously in hypotension.

References: 1.Kunz,W.;Schmid,W.,and Siess,M.: Arzneimittel-Forsch.12:1098,1962. 2.Siess,M.: Arzneimittel-Forsch.12:683,1962. 3.Laudahn,G.: Experientia 17:415,1961. 4.Lamprecht,W.: 27th Congress of the German Society for Circulation Research,Bad Nauheim,1961. 5.Hockerts,T.,and Bögelmann,G.: Arzneimittel-Forsch.9:47,1959. 6.Vineberg,A.M.,et al.: Canad.M.A.J.87:336,1962. 7.Chari,S.R.et al.: Presented at the International Congress of Chest Physicians,New Delhi,1963. 8.Neuhaus,G.,et al.: Presented at the Fourth World Congress of Cardiology,Mexico City,1962. 9.Asada, S.,et al.: Japanese Circ.J.27:849,1962.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York, Distributors

PE-2254

cut Rx writing by 2/3 in colds, flu or grippe

NAME _____

ADDRESS _____

℞

No need to write three separate prescriptions for antitussive, decongestant and analgesic relief of common cold, flu or grippe symptoms when it is therapeutically correct... economically sound... to specify

ANTITUSSIVE/DECONGESTANT/ANALGESIC 'EMPRAZIL-C'® TABLETS

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Phenacetin	150 mg.
Aspirin	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming

'Emprazil-C' Tablets are available on prescription only.

Dosage: Adults and children over 12 years—1 or 2 tablets—3 times daily as required. Children 6 to 12 years—1 tablet—3 times daily as required. **Caution:** While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed. **Supplied:** Bottles of 100 tablets.

Also available without codeine as 'EMPRAZIL'® TABLETS

Complete literature available on request from Professional Services Dept. PML.



BURROUGHS WELLCOME & CO (U.S.A.) INC.

Tuckahoe, N. Y.



For peptic ulcer gastric hyperacidity and gastritis...

In year-long study on peptic-ulcer patients

New Creamalin®

Antacid Tablets

*"...faster in onset of action...and for a longer period"**

"Clinical studies in 85 patients with duodenal ulcer ...confirmed the superiority of the new preparation [new Creamalin] over standard aluminum hydroxide preparations, in that prompt relief was achieved and maintained throughout the period of observation."*

Patients were followed for about one year.

New Creamalin promotes ulcer healing, permits less frequent feedings because it is so long-acting. Heartburn and epigastric distress were "...easily and adequately controlled...."* New Creamalin has the therapeutic advantage of a liquid antacid with the convenience of a palatable tablet. *It does not cause constipation.*

Each new Creamalin tablet contains 320 mg. of specially processed highly reactive dried aluminum gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles offer a vastly increased surface area.

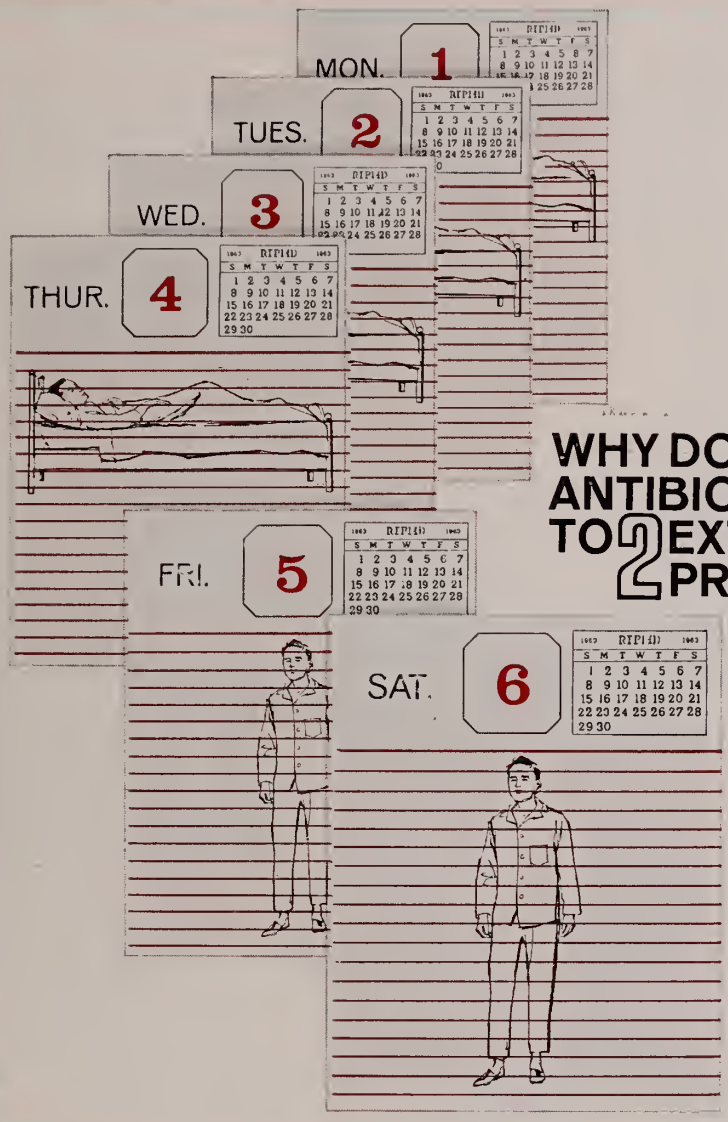
Dosage: Gastric hyperacidity—from 2 to 4 tablets as needed. Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours. *How Supplied:* Bottles of 50, 100, 200 and 1000.

Now also available—New Creamalin Improved Formula Liquid. Pleasant mint flavor—creamy pink color. Stabilized reactive aluminum and magnesium hydroxide gel (1 teaspoon equals 1 tablet). Bottles of 8 and 16 fl. oz.

Creamalin, trademark reg. U.S. Pat. Off.

*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961.

Winthrop LABORATORIES New York 18, N. Y.



WHY DOES ONE ANTIBIOTIC GIVE UP TO 2 EXTRA DAYS' PROTECTION?

Because it is more resistant to disintegration, has a lower renal clearance rate than earlier tetracyclines[1]...a favorable depot effect resulting from protein binding and greater mg. potency...all giving higher, sustained *in vivo* activity which continues long after the last dose.

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE HCl

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. *Side Effects* typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. *Capsules*, 150 mg. and 75 mg. of demethylchlortetracycline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 mg. b.i.d.

1. Kunin, C. M.; Dornbush, A. C., and Finland, M.: Distribution and Excretion of Four Tetracycline Analogues in Normal Young Men. *J. Clin. Invest.* 38:1950 (Nov.) 1959.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

7187-3

PROFESSIONAL LIABILITY INSURANCE PROGRAM

officially endorsed by

THE MEDICAL SOCIETY OF NEW JERSEY

PROTECTION for Professional Acts and Professional Premises Liability for members of The Medical Society of New Jersey by the First American Liability Insurance Company.

LOSS CONTROL. Your County Medical Review and Advisory Committee will evaluate malpractice cases and recommend the action which would be most favorable for the Medical Profession, the Defendant Doctor, the Patient and the Public. This program permits understanding of the complex problems involved in such cases and calls for close cooperation between the Medical Profession and Insurance Company.

MEDICO-LEGAL FORMS are furnished to each insured doctor to help in reducing claims or dissatisfied patients. Failure to use forms does not affect the doctor's insurance coverage or his eligibility for insurance.

INSURANCE COUNSELING. Insurance counseling and advice, available at all times, without cost, to help you with your Professional Liability insurance problems.

CANCELLATION. No policy will be cancelled or non-renewed without prior consultation between your Society and the Company and this is a matter of complete cooperation for the best interests of all concerned.

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY

Policies Guaranteed Non-assessable

Professional Liability Department

123 CLEVELAND STREET — ORANGE, NEW JERSEY

Joseph A. Britton, Manager — ORange 3-2575

Home Office: Wakefield, Mass.



*This one in the High Sierras, California

...nothing, that is, except the sedative-antispasmodic action of

Donnatal®

Robins

In each Tablet, Capsule or 5 cc. Elixir		In each Extentab
0.1037 mg.	hyoscyamine sulfate	0.3111 mg.
0.0194 mg.	atropine sulfate	0.0582 mg.
0.0065 mg.	hyoscine hydrobromide	0.0195 mg.
16.2 mg. (¼ gr.)	phenobarbital	(¾ gr.) 48.6 mg.

(Warning: May be habit forming)

No serious toxic reactions are to be anticipated. Dryness of the mouth, blurred vision, difficult urination, and flushing and dryness of the skin may occur with excessive and prolonged dosage, but promptly disappear with reduction in dosage. Contraindicated in acute glaucoma, advanced hepatic or renal disease, or idiosyncrasy to any component. Use with care in incipient glaucoma or urinary bladder neck obstruction.

A. H. ROBINS CO., INC., Richmond 20, Virginia

Prescribed by more physicians than any other antispasmodic—*well over 5 billion doses!*


when 'pain & spasm'*

call for analgesic-relaxant action···

Whether spasm is induced by pain, or pain by spasm, satisfactory control usually requires analgesic as well as relaxant action. In such cases, ROBAXISAL combats both pain and spasm. When apprehension is a complicating factor, ROBAXISAL-PH is indicated.

Among the many conditions for which ROBAXISAL and ROBAXISAL-PH have been found effective are: strains and sprains, painful disorders of the back, "whiplash" injury, myositis, pain and spasm associated with arthritis, low back pain, torticollis, and headache associated with muscular tension.

Side effects such as lightheadedness, slight drowsiness, dizziness and nausea may infrequently occur but usually disappear on reduction of dosage. There are no specific contraindications other than hypersensitivity to any one of the components.

*Skeletal muscle spasm is a two-headed dragon of 'PAIN & SPASM'



ROBAXISAL®

Each pink-and-white laminated Tablet contains:

ROBAXIN (methocarbamol, Robins)..	400 mg.
U.S. Pat. No. 2770649	
Aspirin (5 gr.)	325 mg.

ROBAXISAL-PH®

Each green-and-white laminated Tablet contains:

ROBAXIN (methocarbamol, Robins)	400 mg.	Hyoscyamine sulfate	0.016 mg.
Phenacetin	97 mg.	Phenobarbital (1/8 gr.)..	8.1 mg.
Aspirin	81 mg.	(Warning: May be habit forming)	

Robins

A. H. ROBINS CO., INC., Richmond 20, Virginia



excessive uterine bleeding*

"significant improvement..."[1]

duo-CVP®

(double-strength CVP)

In patients in whom there was "flooding" (associated with menorrhagia for which no organic cause could be isolated), non-hormonal therapy with duo-C.V.P. achieved "excellent" results as assessed by easy control of bleeding, improved sense of well-being, and ability to maintain normal activities. "In no case has there been any instance of side effects."[1]

The clinician attributes the anti-hemorrhagic effects of duo-C.V.P. to its apparent ability to restore normal small vessel structural integrity and function.

duo-C.V.P. and C.V.P.† have also been reported of value in the treatment of capillary bleeding associated with other gynecologic conditions such as threatened and habitual abortion, post-partum bleeding and functional menometrorrhagia.[2-5]

Each duo-C.V.P. capsule provides:	
CITRUS BIOFLAVONOID COMPOUND	200 mg.
ASCORBIC ACID (VITAMIN C)	200 mg.

Bottles of 50, 100, 500 and 1000 capsules.

†C.V.P. provides in each capsule 100 mg. of an exclusive citrus bioflavonoid compound and 100 mg. of ascorbic acid. Bottles of 100, 500 and 1000 capsules.

references: 1. Prueter, G. W.: Applied Therapeutics 3:351, 1961. 2. Taylor, F. A.: West J. Surg., Obstet. & Gynec. 64:280, 1956. 3. Ainslie, W. H.: Obstet. & Gynec. 13:185, 1959. 4. Pearse, H. A., and Trisler, J. D.: Clin. Med. 4:1081, 1957. 5. Clemetson, C. A. B., and Blair, L. M.: Am. J. Obst. & Gynec. 83:1269, 1962.

menorrhagia*

Samples and literature from

u. s. vitamin & pharmaceutical corp.

Arlington-Funk Laboratories, division • New York 17, N. Y.





Smooths out emotional peaks and valleys

'Meprospan'-400 brand of meprobamate contains 400 mg. in sustained-release form. One capsule smooths out the anxious patient's emotional peaks and valleys for 10 to 12 hours — and provides these other advantages:

1. **Especially suitable for maintenance therapy.** Patients whose anxiety has diminished to a mild or moderate level still require a certain amount of tranquilization throughout the day. Sustained-release action is ideally suited to this type of patient.
2. **Simpler dosage schedule.** Since one capsule of 'Meprospan'-400 (meprobamate, sustained release) acts 10 to 12 hours, the patient enjoys a much simpler dosage schedule than with tablets — and is less likely to forget to take the medicine.

Side Effects: Rarely, skin reactions. May increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence in patients with history of drug or alcohol addiction.

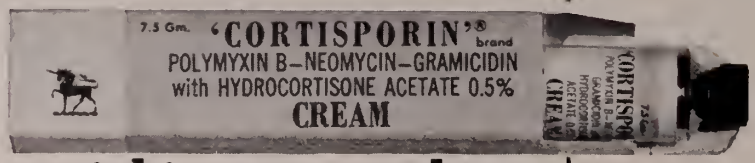
Available: *'Meprospan'-400* (meprobamate, sustained release) contains meprobamate 400 mg. *'Meprospan'-200* (meprobamate, sustained release) contains meprobamate 200 mg. Both potencies in bottles of 30. **Usual dosage:** One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Meprospan®-400
meprobamate 400 mg
sustained release

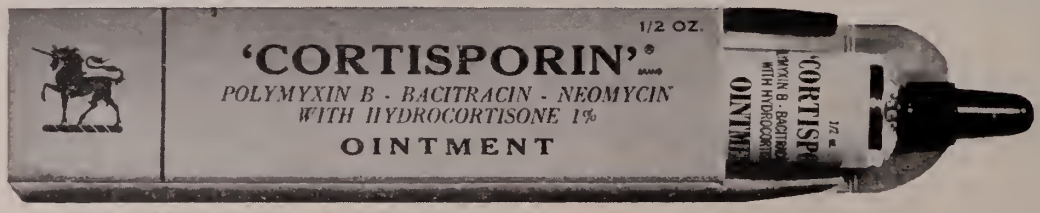
WALLACE LABORATORIES / *Cranbury, N.J.*

CME-2133

CHOOSE THE PRODUCT TO FIT THE NEED



a new vanishing cream base



a special low melting point base

anti-inflammatory
bactericidal
antipruritic
rarely sensitizing

CREAM—*Ingredients:* Each gram contains 'Aerosporin'® brand Polymyxin B* Sulfate 10,000 Units; Neomycin Sulfate (equivalent to 3.5 mg. Neomycin Base) 5.0 mg.; Gramicidin 0.25 mg.; Hydrocortisone Acetate 5.0 mg. (0.5%).

In a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, distilled water, and 0.25% methylparaben as preservative.

Available: In tubes of 7.5 Grams.

OINTMENT—*Ingredients:* Each gram contains 'Aerosporin'® brand Polymyxin B* Sulfate 5,000 Units; Zinc Bacitracin 500 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base); Hydrocortisone 10 mg. (1%).

In a special white petrolatum base.

Available: In tubes of ½ oz. and ⅛ oz.

*U.S. Patent Nos. 2,565,057–2,695,261

Indications: Wherever inflammation or infection occurs and is accessible for topical therapy.

Contraindications: These drugs are contraindicated in tuberculous, fungal or viral lesions (herpes simplex, vaccinia and varicella).

Caution: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



The new specialist

(concentrates on coughs)

Tussicalm, by concentrating solely on cough relief, permits therapeutic and dosage flexibility in treating individual patients, since other symptoms may vary in type, frequency, onset and duration. Mixtures with multi-therapeutic effects may be unnecessary, increase danger of side effects, and result in "inadequate concentrations of effective ingredients...."[1]

With Tussicalm, patients receive concentrated 2-way action.

Noscapine—safe, effective cough suppressant.[2,3] Antitussive potency equal to codeine.[1,4-7] No addiction liability.[1,6,7] Wide margin of safety.[6-8] No opiate-like effects, such as constipation, respiratory depression or blood pressure changes.[5]

Glyceryl Guaiacolate—safe, superior expectorant. Greatly increases and thins bronchial secretions.[9] Facilitates elimination of sputum and soothes irritated bronchial mucosa.[10] Virtually no adverse effects.[9]

Tussicalm, being essentially free of side effects, is available to the whole family without prescription.

ROUSSEL CORPORATION, 155 E. 44 ST., N.Y. 17, N.Y. ROUSSEL

Each teaspoonful (5 cc.) contains in a delightfully different tasting syrup: Noscapine 10 mg., Glyceryl Guaiacolate 90 mg., Citric Acid Anhydrous 75 mg., and Sodium Benzoate 5 mg. DOSAGE: *Adults:* 2 teaspoonfuls three or four times daily. *Children* (6 to 12): 1 teaspoonful three or four times daily. *Children* (4 to 6): ½ to 1 teaspoonful three or four times daily. SUPPLIED: 4-oz. bottles.

REFERENCES: (1) Bickerman, H. A.: M. Clin. N. America *45*:805, 1961. (2) Bickerman, H. A., & Barach, A. L.: Am. J. M. Sc. *228*:156, 1954. (3) Segal, M. S.; Goldstein, M. M., & Attinger, E. O.: Dis. Chest *32*:305, 1957. (4) Bickerman, H. A. ; German, E.; Cohen, B. M., & Itkin, S. E.: Am. J. M. Sc. *234*:191, 1957. (5) New and Nonofficial Drugs, Evaluation by A.M.A. Council on Drugs, Philadelphia, J. B. Lippincott Company, 1962, p. 453. (6) Bickerman, H. A., *in* Modell, W., ed.: Drugs of Choice 1962-1963, St. Louis, The C. V. Mosby Company, 1962, p. 469. (7) Bickerman, H. A.: Clin.

there is nothing "new" about Thorazine®



brand of

chlorpromazine

In the nine years since it became available to American physicians, Thorazine (chlorpromazine, SK&F) has been more widely used, more thoroughly investigated and more extensively documented than any other agent of its type.

Its actions, effects—and side effects—are well known throughout the medical profession. Its efficacy has been clearly demonstrated. And when properly used, its advantages far outweigh any possible disadvantages.

This is why there is nothing "new" about Thorazine (chlorpromazine, SK&F). This is why it remains the first choice in many conditions—and the standard against which other agents are inevitably compared.

This is why it is one of the fundamental drugs in medicine.

SMITH KLINE & FRENCH
LABORATORIES, PHILADELPHIA

SK&F

blood, milk and Maalox®

(magnesium-aluminum hydroxide gel)

Practically standard treatment, now, for bleeding ulcer. Why is Maalox included? Antacid therapy *must* continue long after the wound has healed, and patients started on Maalox tend to stay on Maalox. It tastes good;, it's effective and will not cause constipation—three important reasons for Maalox over the long haul. Some physicians, we are told, order Maalox routinely for hospital patients on drugs which could irritate. They feel it reduces the likelihood of gastric discomfort. Supplied: Suspension; Tablets No. 1; Tablets No. 2. (Each Maalox No. 1 Tablet is equivalent to 1 teaspoonful and each Maalox No. 2 Tablet is equivalent to 2 teaspoonfuls of Suspension.)



ROHER

WILLIAM H. RORER, INC., FORT WASHINGTON, PA.



BLUE SHIELD
-- an opportunity!

Blue Shield offers each of its 6,700 Participating Physicians in New Jersey an opportunity to do something specific about the future of medical care in America.

The very fact that physicians participate in Blue Shield is a statement of their belief in voluntary prepayment medical care. To take full advantage of the opportunity offered by Blue Shield most physicians do more than just participate. They make certain that their subscribing patients receive the full benefits of their contracts. By doing this they help to make Blue Shield a symbol of protection against economic catastrophe and a guarantee of the highest quality of medical care under the free enterprise system.

And the one New Jersey physician in five who has not yet joined Blue Shield can help to meet today's opportunity — by participation.



BLUE SHIELD®
Medical-Surgical Plan of New Jersey
500 Broad Street, Newark



For comprehensive control of the whole pain complex...

Like a triad, the action of Trancogesic is direct and simple as 1,2,3. Its tranquilaxant component – chlormezanone – 1. reduces emotional reaction to pain . . . 2. decreases skeletal muscle spasm . . . and 3. its aspirin component dims the patient's perception of pain. Thus, Trancogesic controls the *whole* pain complex – *with unsurpassed tolerance.*

Each tablet of Trancogesic contains 100 mg. of chlormezanone and 300 mg. (5 grains) of aspirin. The usual adult dosage is 2 tablets of Trancogesic three or four times daily. Reactions to Trancogesic have been minor – gastric distress, and an occasional weakness, sedation or dizziness. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. Trancogesic is contrainindicated in persons known or suspected to have an idiosyncrasy to aspirin.

WINTHROP LABORATORIES, NEW YORK 18, N. Y.

TRANCOGESIC*
CHLORMEZANONE 100 MG. with ASPIRIN 300 MG.

*TRADEMARK

Winthrop

1777M

The one tranquilizer that

BELONGS IN EVERY PRACTICE

it's versatile: The years have proved that 'Miltown' (meprobamate) is the one tranquilizer that is helpful in almost every aspect of daily practice. Virtually any of your patients, regardless of age, can be given the drug with confidence, either as a primary treatment or as an adjunct to other therapy.

Outstanding record of safety: Over eight years of clinical use among millions of patients throughout the world — plus more than 1500 published reports covering the use of the drug in almost every field of medicine — support your prescriptions for 'Miltown' (meprobamate). This is why it *"belongs in every practice."*

dependable: 'Miltown' (meprobamate) is an established drug. There are no surprises in store for you or your patient. You can depend on it to help your patients through periods of emotional distress — and to help maintain their emotional stability.

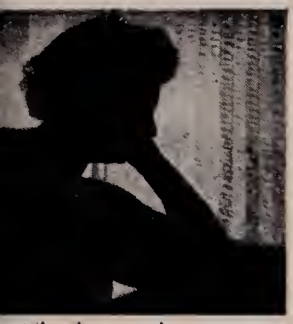
easy to use: Because 'Miltown' (meprobamate) is compatible with almost any other kind of drug therapy, you'll find it fits in easily with any program of treatment you are now using. It will not, therefore, complicate treatment of patients seen in clinical practice.

BRIEF SUMMARY: *Indications:* Anxiety and tension states, and all conditions in which anxiety and tension are symptoms. *Side Effects:* Slight drowsiness may occur and, rarely, allergic or idiosyncratic reactions, generally developing after 1-4 doses of the drug. *Contraindications:* Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. *Precautions:* Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities, to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available to physicians on request.*

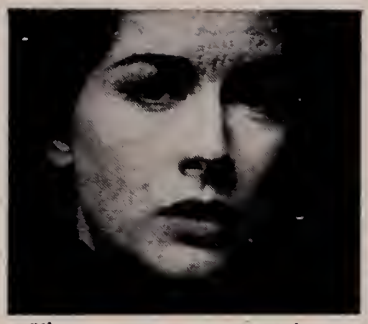
USUAL ADULT DOSAGE: 1 or 2 400 mg. tablets t.i.d.

SUPPLIED: 400 mg. scored tablets, 200 mg. coated tablets.

CM-9574



The Insomniac



The tense, nervous patient



The heart-disease patient



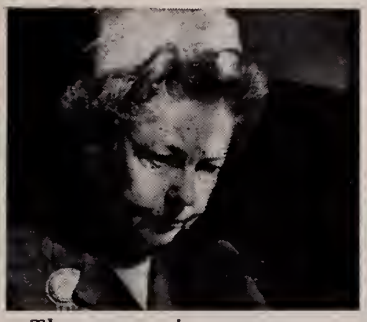
The surgical patient



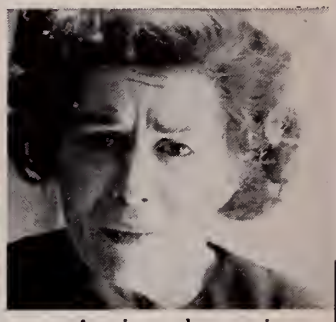
e girl with dermatosis



Tension headache



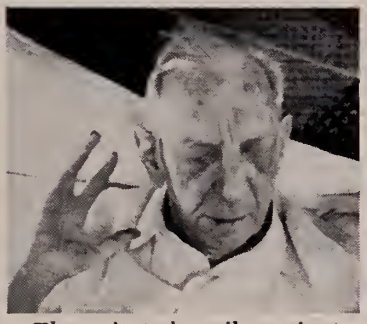
The woman in menopause



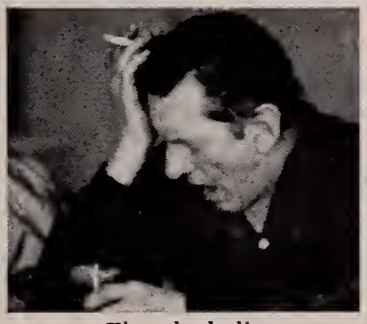
Anxious depression



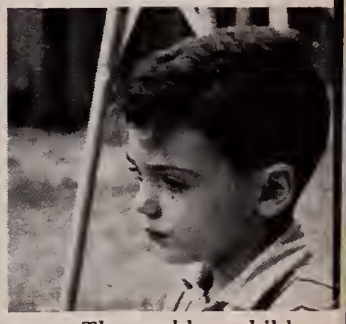
remenstrual tension



The agitated senile patient



The alcoholic



The problem child

the original brand of
meprobamate

Miltown®



The G.I. patient

WALLACE LABORATORIES
Cranbury, N.J.

The Medical Society of New Jersey

Endorsed Insurance Plans

ACCIDENT AND HEALTH INSURANCE

$ 1,200 a month new maximum Basic total disability benefit

ACCIDENT: from 1st day, up to 5 years (Partial Accident Disability, half benefit up to six months)
SICKNESS: from 8th day, up to 2 years

$600 a month new maximum Extended total disability benefit, continuing benefits beyond basic coverage.

ACCIDENT: extended to LIFE
SICKNESS: extended through SEVENTH year

MAJOR MEDICAL EXPENSE INSURANCE

$10,000 maximum for Covered Expenses for each accident or sickness, covering member, spouse, and eligible children. Plan pays 80% Covered Expenses after $500 deductible.

LIFE INSURANCE

$10,000 to **$50,000** of Convertible Term Life Insurance.

(Guaranteed exchangeable at any time into Permanent Cash Value life insurance without medical examination)

Applications for initial $10,000 policy and additional $10,000 policies up to $50,000 total under this plan considered during the month of November each year.

SIX POINT, HIGH LIMIT ACCIDENT INSURANCE

Up to $200,000 for member, covering accidental death, dismemberment, loss of sight, total and permanent disability, exposure and disappearance.

Up to $100,000 for spouse (without disability benefit).

Applications are subject to age limits and other company rules and regulations for acceptance of risk. New members have special privileges during the first few months of membership; ask for specific details if you were recently elected and have not received notification from us.

Information and claim service are as close as your telephone.

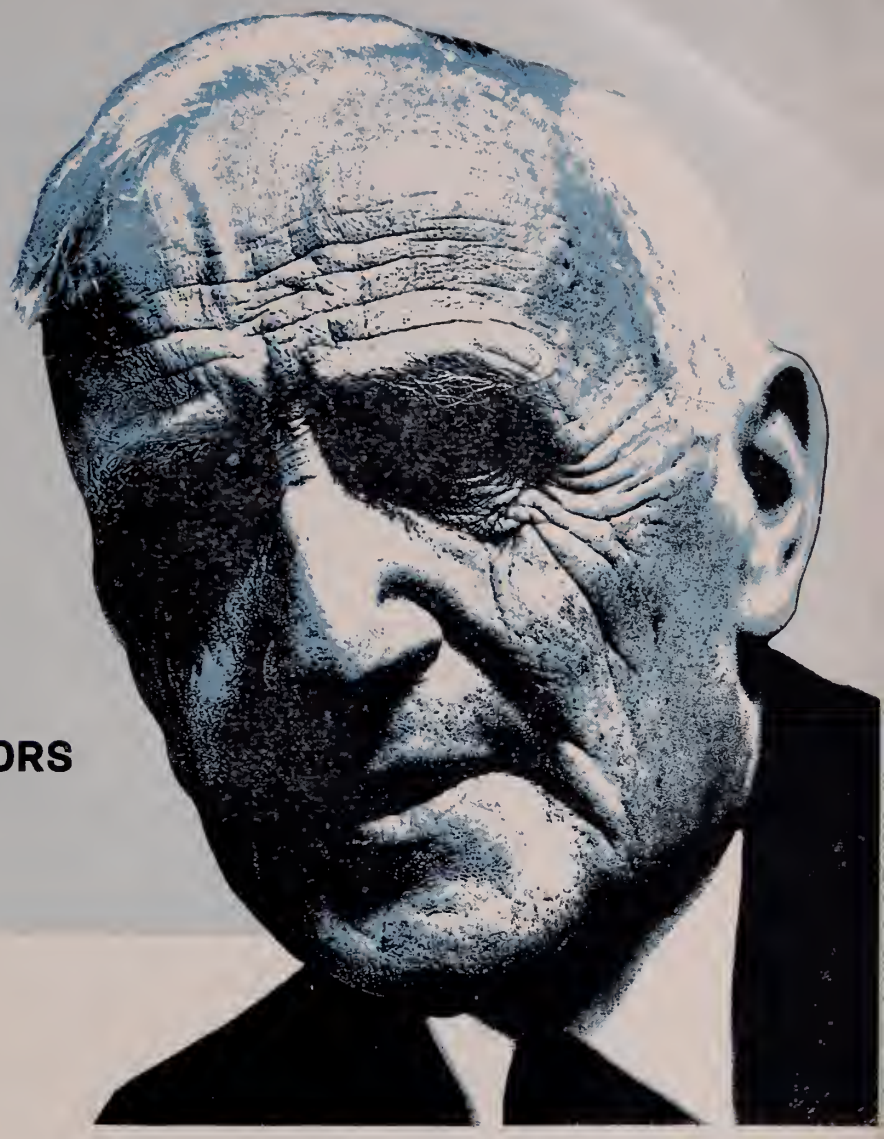
E. & W. BLANKSTEEN

E. & W. Blanksteen Agency, Inc.

75 MONTGOMERY STREET JERSEY CITY, NEW JERSEY 07302

DElaware 3-4340 (Area Code 201)

For your elderly arthritic patients



AN EFFECTIVE GERIATRIC ANTIARTHRITIC WITH ESSENTIAL SAFETY FACTORS

safely indicated – even in the presence of **HYPERGLYCEMIA**

PABALATE-SF may be prescribed with confidence to elderly arthritics—even in the presence of hyperglycemia—because of its widely recognized **Safety Factors:** (1) its potassium salts cannot contribute to sodium retention; (2) its enteric coating assures gastric tolerance; and (3) its use is free from the serious reactions in diabetic patients sometimes noted during therapy with steroids or pyrazolone derivatives. As for effectiveness, it has been found "superior to aspirin in the treatment of chronic rheumatic disorders."[1]

Each persian-rose enteric-coated tablet contains: potassium salicylate, 0.3 Gm.; potassium para-aminobenzoate, 0.3 Gm.; ascorbic acid, 50 mg.

1. Ford, R. A., and Blanchard, K. P.: J.-Lancet 78:185, 1958.

Precaution: Occasionally, mild salicylism may occur, but this responds readily to dosage adjustment. In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Supply: Bottles of 100 and 500 enteric-coated tablets.

Pabalate®-SF

Robins

(the new, convenient way to prescribe Pabalate-Sodium Free)

A. H. ROBINS COMPANY, INC., RICHMOND, VIRGINIA

"Doctor... I'm so tired all the time"



Lethargic patients respond to Ritalin

(methylphenidate hydrochloride)

When lethargy is a medical problem—in convalescence, chronic fatigue, mild depression, menopause, oversedation, and senility, for example—the gentle stimulant action of Ritalin (methylphenidate hydrochloride) restores normal physical and mental activity.

In his report, Siegler[1] states: "In mild depression or in clinical exhaustion syndromes, a marginal sympathomimetic drug like methylphenidate seems to be the drug of choice for initiating therapy. It does not have the toxic effects found with the amphetamines or with the hydrazines or other antidepressants."

Other significant comments on the clinical safety of Ritalin (methylphenidate hydrochloride): "At no time was there evidence of serious toxic reactions [in a study of 185 patients]. The drug did not produce alteration in blood forming factors, kidney and liver function."[2]

"No significant toxic effects have resulted after the continuous administration of methylphenidate for more than 3 years."[3]

INDICATIONS: Chronic fatigue.

CONTRAINDICATIONS: Marked anxiety, tension, and agitation.

CAUTION: Should not be used to increase mental or physical capacities beyond normal limits. Use cautiously with epinephrine or levarterenol.

SIDE EFFECTS: Nervousness, insomnia, anorexia, nausea, dizziness, palpitations, headache, drowsiness.

DOSAGE: 10 to 20 mg. b.i.d. or t.i.d.

SUPPLIED: *Tablets*, 5 mg. (pale yellow), 10 mg. (pale blue) and 20 mg. (pale orange).

REFERENCES: 1. Siegler, P. E., in Nodine, J. H., and Moyer, J. H. (Editors): *Psychosomatic Medicine*, The First Hahnemann Symposium, Lea & Febiger, Philadelphia, 1962, p. 582. 2. Lapolla, A.: Western Med. 2:383 (Sept.) 1961. 3. Yoss, R. E., and Daly, D. D.: Pediatrics 25:1025 (June) 1960.

2/3098M●

C I B A SUMMIT, N.J.

Ritalin® hydrochloride (methylphenidate hydrochloride CIBA)



Deltasmyl®

Theophylline (120 mg.)
Ephedrine HCl (15 mg.)
Phenobarbital (8 mg.)
(Barbituric acid derivative)
Prednisone (1.5 mg.)

for safer steroid protection from asthma

DELTASMYL® opens the airways and suppresses inflammation by combining the anti-allergic, anti-inflammatory action of prednisone with the bronchodilating, decongestant and quieting effects of theophylline, ephedrine and phenobarbital.

DELTASMYL provides prompt, prolonged relief of asthma with prednisone protection against allergens and stress, and a wider margin of safety through reduction of the effective corticoid dose.

The aim of therapy in asthma should be relief of bronchospasm by means of decongestant and bronchodilating agents—plus prednisone, not just prednisone alone.[1] Uhde[2]—using theophylline-ephedrine-phenobarbital with prednisone—reports an increase of about 25% in the action of prednisone with quicker arrest of inflammation, hypersecretion, and alveolar stasis; a marked sedative action on heart and circulation; improved ventilation. Bopp[3] also has obtained satisfactory results with the same combination, probably through synergistic enhancement of prednisone potency.

Dosage: One DELTASMYL tablet provides symptomatic relief for 4 hours or longer. Not more than 6 tablets should be taken in 24 hours. Withdraw gradually.

Precautions: DELTASMYL contains ephedrine and should not be given with epinephrine since both drugs may cause tachycardia. Carefully observe patients hypersensitive to sympathomimetic amines. Phenobarbital is a barbituric acid derivative which may be habit forming. Despite the low prednisone dose, all precautions and contraindications of corticosteroids must be heeded, since warning signs such as fluid retention or moon face may not be present. When corticosteroids are given to patients with acute or chronic bacterial infections, appropriate protection should be provided.

Contraindications: Hyperthyroidism, cardiovascular diseases, peptic ulcer, diabetes mellitus, psychotic tendencies, ocular herpes simplex, glaucoma, prostatic hypertrophy, Cushing's syndrome, arrested tuberculosis.

Supplied: Bottles of 50 tablets, on prescription only.

References: 1. Barach, A. L. and Bickerman, H. A.: Pulmonary Emphysema, Baltimore, Williams & Wilkins, 1956, p. 523. 2. Uhde, H.: Med. Monatsschr. No. 8, 505, 1959. 3. Bopp, K. Ph.: Medizinische Klinik 53:186, 1958 and Algerie Medicale 62:1081, 1958.

ROUSSEL

Roussel Corporation

155 East 44th Street, New York 17, N.Y.



Helps speed recovery even in severe muscle injuries

hether your muscle-injury patient is a professional hlete or just a weekend golfer, you can expect rapid sults with 'Soma' (carisoprodol).

This unique drug breaks up both muscle spasm and in at the same time. Onset of action takes only 30 nutes, and your patient will usually begin to feel tter within hours.

As Conant demonstrated in a study of 106 patients th musculoskeletal injuries, 88% of the patients eated with 'Soma' (carisoprodol) achieved good to cellent results. *(Clinical Medicine*, March, 1962.)

Carisoprodol seldom produces side effects. Occa- nal drowsiness may occur, usually at higher than commended dosage. Individual reactions may occur rely. For severe athletic strains or everyday sprains, you can rely on 'Soma' (carisoprodol) to help speed recovery with notable safety.

USUAL DOSAGE: ONE 350 MG. TABLET Q.I.D.

The muscle relaxant with
an independent pain-relieving action

Soma®
carisoprodol

Wallace Laboratories, Cranbury, New Jersey



For dramatic restoration

WINSTROL®

brand of STANOZOLOL

Oral anabolic therapy with this new physiotonic helps restore the patient's: positive protein metabolism; confidence, alertness and sense of well-being.

WINSTROL (stanozolol/Winthrop), a heterocyclic steroid, combines highest potency* with outstanding tolerance, stimulates appetite and promotes weight gain . . . restores a positive metabolic balance. It counteracts the catabolic effects of concomitant corticosteroid or ACTH therapy. WINSTROL (stanozolol/Winthrop) rebuilds body tissue while it builds strength, confidence and a sense of well-being in conditions associated with excess protein breakdown, insufficient protein intake and inadequate nitrogen and mineral retention.

Side Effects and Precautions: Prolonged administration can produce mild hirsutism, acne or voice change. In an occasional patient, edema has been observed and in young women the menstrual periods have been milder and shorter. These side effects are reversible, and patients receiving prolonged treatment should be examined and questioned periodically so that, should side effects appear, the dosage may be reduced or administration of the drug discontinued for a time.

In patients with impaired cardiac and renal function, there is the possibility of sodium and water retention. Liver function tests may reveal an increase in bromsulphalein retention, particularly in elderly patients. In such cases, therapy should be discontinued. Although it has been used in patients with cancer of the prostate, its mild androgenic activity is considered by some investigators to be a contraindication.

Dosage: Usual adult dose, 1 tablet t.i.d. before or with meals; young women, 1 tablet b.i.d.; children (school age): up to 1 tablet t.i.d.; children (preschool age): ½ tablet b.i.d. Available as scored tablets of 2 mg. in bottles of 100. For best results, administer with a high protein diet.

*ANIMAL DATA

Rx WINSTROL (stanozolol/Winthrop) whenever anabolic therapy is indicated

Winthrop

Winthrop Laboratories, New York 18, New York



when the pressure is up...

Rauprote

(RAUWOLFIA SERPENTINA AND PROTOVERATRINES A & B COMBINED)

Rauprote is a combination of proved antihypertensive agents. Rauwolfia Serpentina provides a moderately tranquilizing and hypotensive effect. Protoveratrines A and B bring a quicker, more potent lowering of blood pressure and bradycrotic action. The combination of agents produces a therapeutic effect superior to even large doses of either drug alone, and reduced dosages of both components in Rauprote minimize toxic side effects.[1,2] Rauprote therapy has been shown[2] to induce excellent responses from the majority of patients suffering from mild to moderately severe levels of blood pressure.

REFERENCES: 1. Goodman, L.S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., Macmillan & Co., New York, 1955. 2. Roberts, E.: Four Year Evaluation of an Antihypertensive Agent, J.A.M. Women's Assn. *13*:349, 1958.

FORMULA
Each tablet contains 50 mg. Rauwolfia Serpentina and 0.2 mg. Protoveratrines A and B (alkaloids of *Veratrum Album*).

INDICATION
Management of moderate to severe hypertension.

SIDE EFFECTS
Usually mild and may include nausea, nasal stuffiness, occasional drowsiness and loose stools.

CONTRAINDICATIONS
Mental depression, ulcerative colitis, peptic ulcer. Use with caution in gravid patients.

SUPPLIED
Bottles of 100 and 1000 tablets.

VALE

THE VALE CHEMICAL COMPANY, INC.
ALLENTOWN, PENNSYLVANIA

why does 150 mg.



do more than 250 mg.



of other tetracyclines?

Because it has up to 3½ times the *in vitro* antibacterial activity[1]...combined with lower rate of decay in serum, slower renal clearance...a favorable depot effect, resulting from protein binding...all providing rapid, higher and sustained *in vivo* activity with as much as 2 days' extra activity.

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE HCl

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. *Side Effects* typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. *Capsules,* 150 mg. and 75 mg. of demethylchlortetracycline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 mg. b.i.d. 1. Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.: Demethylchlortetracycline and Tetracycline Compared. Relative *in vitro* Activity and Comparative Serum Concentrations During 7 Days of Continuous Therapy. *Amer. J. Med. Sci.* 243:296 (Mar.) 1962.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

7185-3



"Highly Satisfactory"[1] in 88% of ACNE PATIENTS

COSMEDICAKE®

® 1961 Pat. Applied For

greaseless dehydrated lotion in cake form

Clinically tested[1] in 112 patients with acne vulgaris or acne rosacea, **COSMEDICAKE** produced results that "were cosmetically and therapeutically good in 99." Skin lesions were effectively controlled and masked. None of the patients experienced any adverse effects.[1]

COSMEDICAKE provides adjunctive treatment in acne, facial seborrhea, folliculitis, and other eruptions of cosmetic importance. Its convenience and elegance achieves continued cooperation from grateful patients. Its gentle astringent, keratolytic and antiseptic agents* help dry up excess oiliness, diminish pustules, serve to eliminate comedones, reduce pore size and combat skin bacteria. **COSMEDICAKE** is available in easy-to-use cake form, which when applied with a damp sponge is reconstituted as a fast-drying lotion. There is no separation . . . no precipitation . . . no uneven application or concentration.

The patient looks better, feels more confident as **COSMEDICAKE** helps improve her appearance while the skin lesions heal.



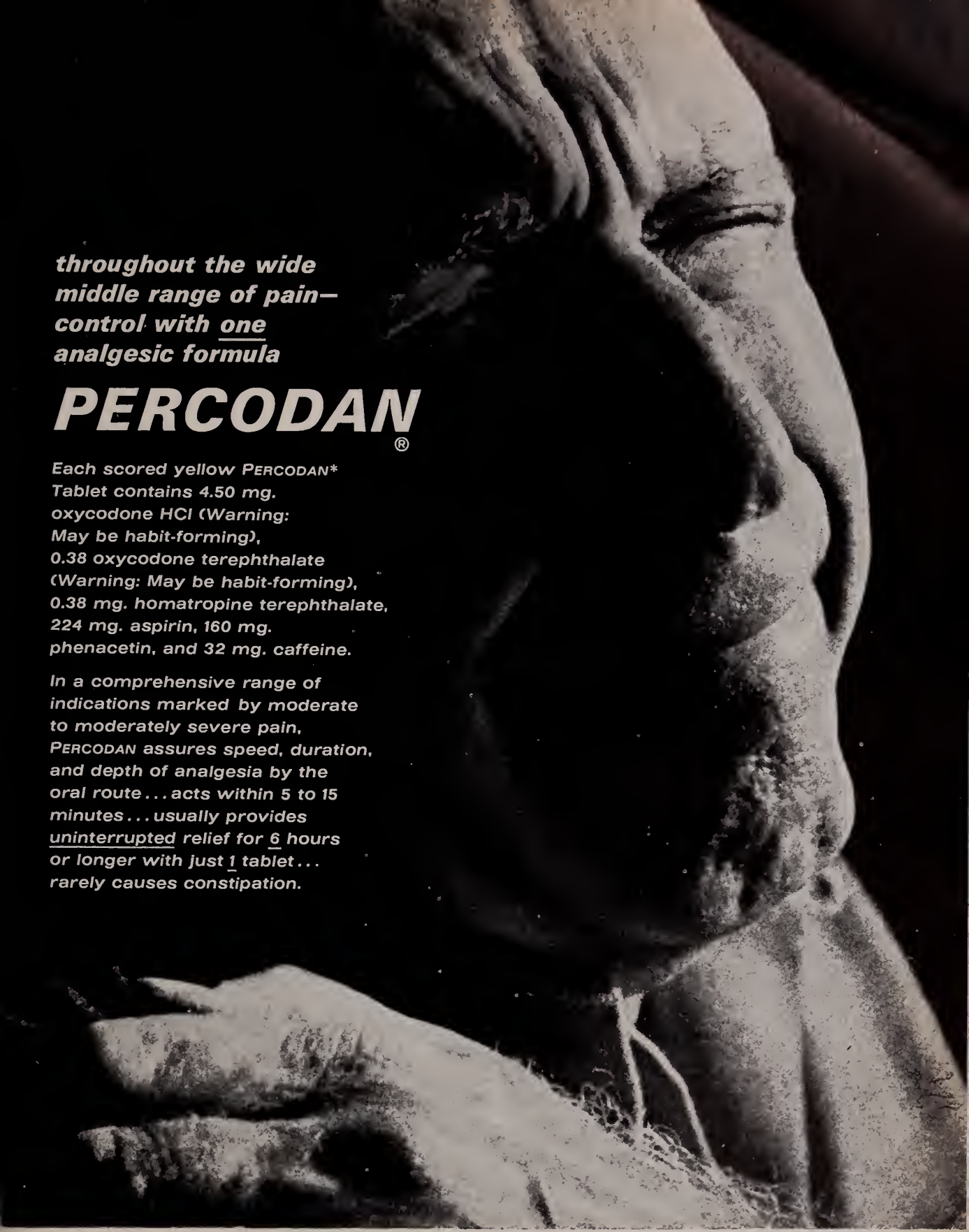
*__COSMEDICAKE__ contains colloidal sulfur, benzalkonium chloride, salicylic acid and hexachlorophene in a smooth, greaseless base. Supplied in four skin-matching colors.

• • •

1. Berger, R.A., Clinical Medicine, Sept. 1961.

FOR SAMPLES AND COMPLETE LITERATURE WRITE

KAY PREPARATIONS COMPANY, INC. 345 West 58 St., N.Y. 19, N.Y.



throughout the wide middle range of pain— control with one analgesic formula

PERCODAN®

Each scored yellow PERCODAN* *Tablet contains 4.50 mg. oxycodone HCl (Warning: May be habit-forming), 0.38 oxycodone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.*

In a comprehensive range of indications marked by moderate to moderately severe pain, PERCODAN *assures speed, duration, and depth of analgesia by the oral route... acts within 5 to 15 minutes... usually provides uninterrupted relief for 6 hours or longer with just 1 tablet... rarely causes constipation.*

Average Adult Dose—1 tablet every 6 hours. **Precautions, Side Effects and Contraindications**—The habit-forming potentialities of Percodan are somewhat less than those of morphine and somewhat greater than those of codeine. The usual precautions should be observed as with other opiate analgesics. Although generally well tolerated, Percodan may cause nausea, emesis, or constipation in some patients. Percodan should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. **Also available:** Percodan®-Demi, containing the complete Percodan formula but with only half the amount of salts of oxycodone and homatropine. Both products are on oral Rx in all states where laws permit. Narcotic order required. Literature on request. **ENDO LABORATORIES Richmond Hill 18, New York**

Endo®



Protects your angina patient better than vasodilators alone

'Miltrate' contains both pentaerythritol tetranitrate, which dilates the patient's coronary arteries, and meprobamate, which relieves his anxiety about his condition. Thus 'Miltrate' protects your angina patient better than vasodilators alone.

Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

Dosage: 1 or 2 tablets *before meals* and at bedtime. Individualization required.
Supplied: Bottles of 50 tablets.

CML-9646

Miltrate®

meprobamate 200 mg.+
pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*

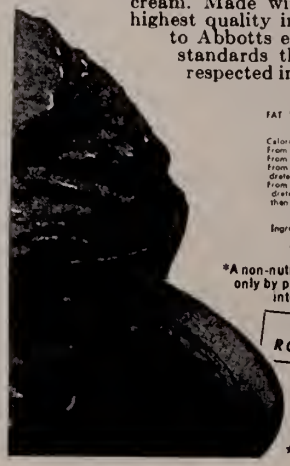
NOW! **DIABETICS CAN ENJOY**
(UNDER MEDICAL ADVICE)

Abbotts

ARTIFICIALLY SWEETENED

ICE CREAM

Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards—standards that are most highly respected in the dairy industry



COMPOSITION

FAT 10.52% PROTEIN 3.71%
CARBOHYDRATES 20.40%

	Per 100 Gm.	Oz. Avoir.	Oz. Fluid
Calories — From Fat	94.68	26.84	16.25
From Protein	14.84	4.21	2.55
From Carbohydrates as Lactose	20.24	5.74	3.47
From Carbohydrates other than Lactose	61.66	17.48	10.58
	191.42	54.27	32.85

Ingredients: Cream, Milk, Sorbitol, Stabilizer and 0.11% Cyclamate Calcium*

*A non-nutritive artificial sweetener for use only by persons who must restrict their intake of ordinary sweets.

IN HANDY ROUND PINTS

At Abbotts and Jane Logan Dealers
Abbotts Dairies

DUGAN'S

"Bakers for the Home"

New - LITE DIET BREAD

(White Bread Baked Without Shortening)
Calories per Slice 42 Calories per oz. 70

ALSO

SALT-FREE BREAD
GLUTEN AND PROTEIN BREADS
100% WHOLE WHEAT
100% Whole Wheat Crackers

New York
Connecticut
New Jersey
Pennsylvania

"At Your Door or To Your Store
It's DUGAN'S for BETTER Baked Goods"

Phone for Delivery

HUmboldt 2-6007 in Newark

(or your local phone book for branch nearest you)

Schering

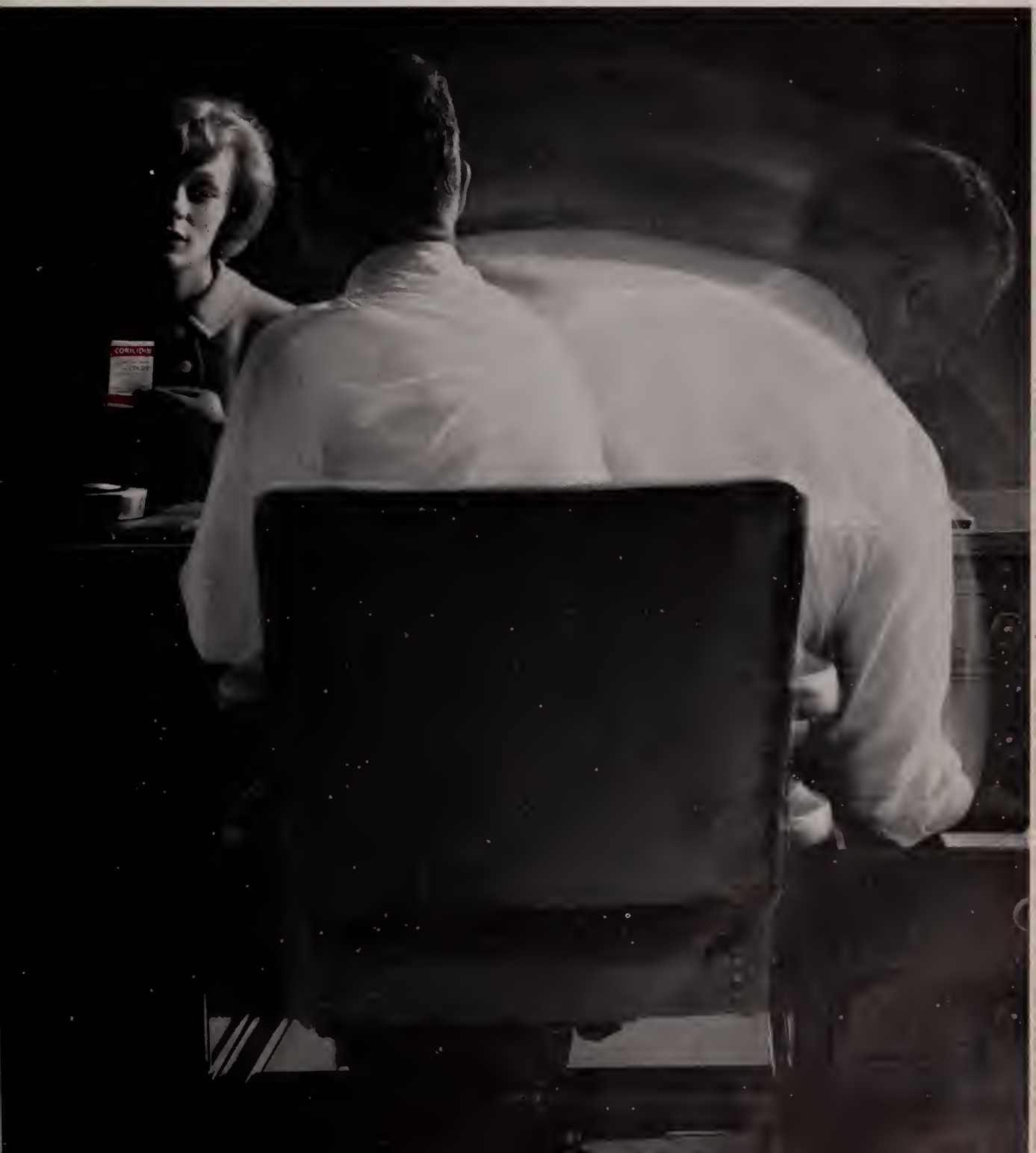
The turning point for effective cold relief

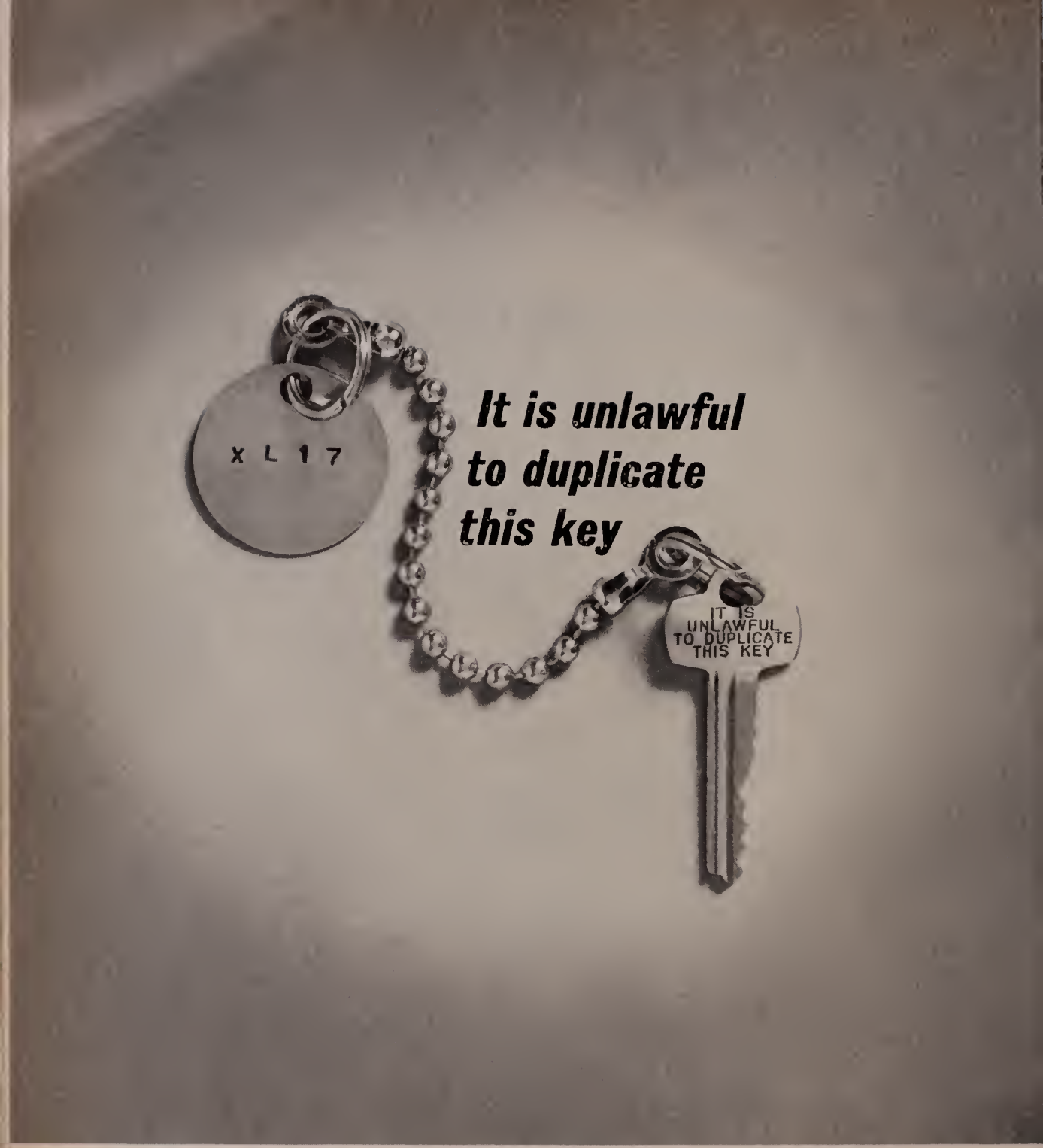
Coricidin®

The most widely used ethical cold preparation in America.

Each CORICIDIN Tablet contains: CHLOR-TRIMETON® (chlorpheniramine) Maleate, 2 mg., aspirin 0.23 Gm., phenacetin 0.16 Gm., caffeine 0.03 Gm. Each CORICIDIN "D" Tablet contains phenylephrine 10 mg. in addition to the above ingredients. CORICIDIN Tablets, brand of antihistaminic-antipyretic-analgesic compound.

S-227





This is the key that opens the box that contains the labels. Only authorized supervisory personnel have the key to transfer labels from the "lockup box" to the labeling machine. ■ These responsible Lilly employees regard labels as serious business. To make certain that the right label appears on each container, all labels are kept under lock and key until needed on the finishing line. Only the quantity needed to finish the lot is dispensed. When transferred to the finishing belt, the appropriate number of labels is placed in the labeling machine. Excess labels are put in the lockup box until needed. At night, the supervisor returns unused labels to the box lest some get lost or misplaced. ■ This is just one more precaution in an endless list of rules that contribute immeasurably to the quality of the finished product.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A. Lilly

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Are Participating Physicians Really Participating?

One of the little-known virtues of Blue Shield is that it offers each individual physician an opportunity to do something specific about the future of medical care in America. Blue Shield challenges every one of us to back up his convictions and to strike a solid blow for medical freedom.

More than 150,000 of us have voluntarily enrolled as "participating physicians." But how many of us truly *participate?* And how many really appreciate the crucial importance of "participation"—of all-out, enthusiastic support for our Blue Shield program?

Blue Shield is not—cannot be—a "spectator sport" for the American physician. On the contrary, it is a physician-participation show, or it's no show at all! And our first duty is to become informed—to know our own Blue Shield program, to understand its problems, its objectives and its specific policies. Secondly, we are challenged to identify ourselves with Blue Shield, and Blue Shield with ourselves. For Blue Shield is not a "third party." *We* are Blue Shield and should speak about it to our patients and friends. We should let the public know what a tremendous social asset it has in Blue Shield, and what a great instrument it can be for the provision of an ever broader program of medical care prepayment by voluntary effort.

True *participation* in Blue Shield means *performance.* It means that we accept unequivocally the responsibility of assuring that Blue Shield provides benefits to whatever extent the subscriber's contract and our own agreement as participating physicians commit us. Let us make Blue Shield a symbol not only of protection against economic catastrophe but also of assurance of the highest quality of medical care for every American.

Published Monthly Since 1904 Henry A. Davidson, M.D., Editor
Under the Direction of the Committee on Publication Theresa E. Goeke, Assistant Editor
George B. Sharbaugh, M.D., Chairman
Place of Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton, N. J.
Send all communications for publication to P.O. Box 904, Trenton, N. J. 08605 — EXPORT 4-3154
Send all communications regarding advertising to Joseph W. Cookson, 370 Morris Ave., Trenton, New Jersey 08611 — EXport 3-7196
Each member of the Society is entitled to receive a copy of The Journal every month
Whole Number of Issues 710

Vol. 60, No. 10 OCTOBER, 1963 50 Cents - $5.00 per year

The Seton Hall Respiratory Project

An interesting example of team work, involving a medical school, a voluntary health agency, and an industrial corporation, was recently launched. Seton Hall College of Medicine and Western Electric (Kearny works) have joined hands to study chronic respiratory and cardiovascular disorders. The project is financed by grants from state and local Tuberculosis and Health Associations. The study is under the direction of Dr. Thomas Gocke, associate professor of preventive medicine at Seton Hall. Working with Dr. Gocke will be Dr. E. Parker Willey, medical director of W.E.'s Kearny works and Dr. Benedict Duffy, chairman of preventive medicine at Jersey City's Pollak Hospital.

The role of smoking and air pollution will be assayed. (Last year, a similar study in Jersey City's public housing projects, revealed that 30 per cent of the cigarette smokers had chronic bronchitis; one of nonsmokers had.)

This kind of project is an example of the benefits that a medical school can bring to a state. In addition to its direct physician-training function, a medical school acts as a crystallizing focus for a research-intellectual atmosphere. And when a voluntary public health agency, along with a huge industrial corporation meet with a medical school for such a project, we have a vivid example of a typically American operation.

The Idea Behind the Word

As that wry commentator, Tom Lehrer, once put it—referring to a great American institution: they do not discriminate by reason of race, religion, color or intelligence. The word "discriminate" has a curiously ambivalent meaning. It refers to an unconscionably bad practice when it identifies a prejudice. Yet, in such phrases as "discriminating person," (or taste) it has a virtuous meaning. It is sometimes possible for a shrewd propagandist to condemn the discriminating practice by tarring it with the brush of prejudice.

For example, in several states, optometrists have supported bills which "would make it mandatory for state government to refrain from distinguishing between optometrists and physicians qualified in ophthalmology." These are commonly referred to as non-discrimination bills.* There you have it. The kind of discrimination which says that only an ophthalmically trained M.D. may tamper with the eye is condemned as "discriminatory." Similarly laymen operating laboratories frown on the New Hampshire statute which permits only M.D.'s to direct such laboratories. "It's discriminatory." (The people of New Hampshire, one might say, have discriminating tastes.)

Another example is the word "monopoly." Lawyers have a monopoly of practicing law; physicians have a monopoly of treating the sick; elected legislators have a monopoly of enacting laws. These monopolies are obviously necessary. But the term "monopoly" has become a dirty word. For some years after the end of World War II, many cultist groups tried to persuade the Veterans Administration to allow any "practitioner" selected by a veteran to treat him at Government expense. When the VA protested that they wanted only physicians and dentists to treat veterans, the cultist groups cried "monopoly."

Exploitation of the halo effects of words has become one of the gimmicks in the armory of the "communications expert." It is easier to sell life insurance than death insurance. It is easier to sell health insurance than sickness insurance. What we think of as "professional liability" can be given the pejorative label of "malpractice." A bill for hospital care of the aged (which has no provision for medical care) can be euphemized as "medicare" making it sound as if it offered medical care. What is a compulsory tax to one group is social security to another. The word "compulsory" is bad; the word "security" is good.

Words are handles to ideas. They can also mask ideas.

*From the June 1963 *News Bulletin* of the National Medical Foundation for Eye Care.

FRANK K. KENT*
Trenton

Hospital Costs

Here are some facts to help the physician explain hospital costs to the complaining patient.

HOSPITAL costs have raised sharp outcries from insurance commissioners, magazines, public officials, labor leaders, and the press and general public across the nation. Hospitals are blamed for high costs; physicians are accused of "upping" these costs.

The Hospital Association of New Jersey is deeply concerned about the rising costs of hospital care and feels it has a joint responsibility with The Medical Society of New Jersey to see that these charges do not go unanswered. There is an honest, logical answer to every assertion of high hospital costs. Americans today are getting more for their medical care dollar than ever before. But the hospital patient (one out of every eight each year) must be informed of the facts.

In his presidential address at the 1961 Annual Meeting of the American Hospital Association in Atlantic City, Doctor Jack Mazur made this significant statement: "Hospital costs have gone up 111 per cent during the past 10 years. But the quality of hospital care has gone up to a much greater degree. Although the American people want the best that modern medicine can provide, many people do not accept the fact that this higher quality has brought with it a justifiably higher cost."

It is essential then that there be a unified effort on the part of New Jersey hospitals and physicians. We must jointly agree on a diagnosis and a prescription for the future!

The hospitals, through the Association's trustee liaison committee with The Medical Society of New Jersey, have worked together on problems of common concern many times in the past. Today we must join forces in a campaign to explain hospital costs to the public.

There was a time when all the physician had to do was practice good medicine. Today, in addition to the practice of medicine, the physicians must be willing to help in maintaining America's unique system of medical and hospital care as well. Because of his individual relationship with his patients each physician has an excellent opportunity to explain hospital costs. Each physician can help to create an understanding public. Here's how:

HOSPITALS ARE PEOPLE SERVING PEOPLE

ON THE average, 65 cents of each dollar of hospital expense is for payroll; the balance is spent for equipment, drugs, food and supplies. If wages and salaries in your community increase, then the hospital's major expense (payroll) has to rise too. Hospitals' wages are influenced by the community's salary level. In dollar terms, hospital payrolls today are four times what they were in 1946! There are now 9000 part-time and 46,000 full-time people employed in the hospitals of New Jersey.

Why this sky-rocket increase in hospital payrolls?

*Mr. Kent is Assistant Director of the New Jersey Hospital Association.

Simply this: more people are using hospital services than ever before. Hospitals are personal service institutions: people serving people.

"If machines could save a human life, if equipment could practice medicine, the cost of hospital care would be reduced an estimated 60 per cent," says Jack Owen, Executive Vice-President and Director of the New Jersey Hospital Association.

"Machines have their place, of course, in certain hospital departments, but it takes people to meet the special needs of patients. People mean payroll. Salaries and wages accounted for the lion's share of the increase in hospital costs during the past decade. Two-thirds or more of a hospital's expenses are for payroll."

To retain competent employees hospitals have had to raise wages toward community levels. This is further complicated by the large number of employees which a hospital must hire. In some of the larger hospitals there are as many as 200 job classifications.

A hospital must be staffed 24 hours a day, seven days a week. The hospital work week is 168 hours, which is more than four times the average 40-hour week. Patients must be served every day, every night, every weekend.

The average patient never sees a major portion of the hospital nor the people who work there. That's why he doesn't realize that, in addition to doctors and nurses, there are many other employees serving him in the laboratories, the kitchen, the pharmacy, the supply room, the maintenance department, the laundry, the sterilizing room and the housekeeping department.

The growing number of services provided by hospitals is another factor in the increase in hospital personnel and wages.

New medical discoveries and advances, centered in hospitals, require more and better trained personnel, new and often more expensive equipment. New medical or scientific equipment requires trained personnel.

Today the public is familiar with radioisotopes, cervical cancer tests, "frozen surgery," artificial kidneys, antibiotic therapy, eye and bone banks, defibrillators, recovery rooms, and so on, all new life-saving developments designed to restore health. To provide this better hospital care means additional workers with greater skills, and at higher salaries.

Mr. Owen states, "Hospital care today is one of the greatest bargains available anywhere. The cost of hospital care is indeed higher than ever before. But more of us get well, we get well faster, and we live longer. The cost of living is worth it."

THE COST OF LIVING

How is a human life valued in terms of dollars and cents? How much is the "cost of living" worth?

Saving the patient, the goal of every hospital, has been made possible by the incredible advances in medical science. There was a time, and not so long ago, that hospitals were looked upon as convenient places to die.

But the character of hospitals has changed in recent years through medical advances, through new drugs and medicines and through new equipment. The product of hospitals today is the restoration of health and extended life.

This has meant that, to guarantee the best possible care, hospitals have to employ the best equipment, the best skilled personnel and the best is always expensive.

Warren G. Rainier, President of the New Jersey Hospital Association and Administrator of the Mountainside Hospital, Montclair, states, "Hospitals can't quibble about price. There are no shortcuts to the best care for patients. Hospitals can never put price before quality in the things they buy. Hospitals must hold to rigid standards. We do, and we pay for them."

Administrators are expected to run hospitals on modern business principles—but only to a point. Hospitals are expected to give care "regardless of ability to pay." A business, which operated on this basis would soon be out of business. One official recently said that "Hospitals must make unbusinesslike judgments day after day."

"We add services and purchase new equipment that we know can never pay for them-

selves," he added. "When your medical staff says to you as a hospital trustee, 'this will save a life, this will return a child's hearing, this will help the lame to walk', what do you do as a trustee? If you take the position of a realistic businessman, you don't sleep very well at night."

Today's heart-lung machine is a miracle of research. This machine costs about $15,000. With the help of about fifteen highly-trained professional people, it can save a life.

A two-million volt x-ray installation is one of the newest, most effective weapons against cancer. It costs about $125,000 for the machine alone. With protective housing and insulation, the total comes to about $200,000. The men and women required to handle this equipment must be highly trained. They are worth their salaries.

New Jersey voluntary, non-profit hospitals must have income to meet expenses. It is the payment from the patient for services rendered which provides the major share of the hospitals' operating expenses, with payrolls representing about two-thirds of these expenses.

Hospital and health care today is one of society's greatest bargains, and better hospital care is worth every bit of the higher cost.

TRAINING, RESEARCH AND A COMMUNITY INDUSTRY

THE cost of the care hospitals offer is one of the most significant and most pressing problems facing hospitals today in terms of their relationship with the people they serve. Many who are critical of hospital costs do not realize that the "product" their hospital dollars buy today is vastly superior to that of 20, or even 10 years ago.

One out of every 45 persons works in a hospital. Some hospitals have as many as 200 job classifications.

Today's modern hospital underwrites the training of many of these employees. For instance, 1,200 hospitals across the nation train the professional nurses needed by hospitals, doctors' offices, armed forces, laboratories, government and industry. Hospitals conduct schools for medical record librarians, medical and x-ray technologists and nurse anesthetists. They provide field training for hospital administrators, dietitians and occupation therapists. And thousands of informal programs of education are going on in hospitals to train people in the specific skills needed for the non-professional departments of the hospital.

Still another hospital function is medical research. Almost all of the discoveries that have given us new technics of patient care have been made in hospitals or were perfected by hospital research to the point where they could be put to practical use in the saving of lives. Today more and more community hospitals are conducting research projects which supply important medical data.

In addition to their healing, teaching and research functions, hospitals are important community industries. As consumers of goods and purveyors of service, hospitals rank among the largest. They prepare and serve more than two billion meals every year. They consume nearly two and a half billion pounds of ice per year. And they use two and a half billion kilowatt hours of electrical energy and 63 billion gallons of hot water in a year.

Hospitals are concerned with the rising cost of health care. Hospitals are constantly searching for areas where greater efficiencies can be effected without lowering their standard of personalized patient care. Studies have resulted in such efficiencies as group purchasing of supplies, methods improvement, work simplification technics, and cost accounting.

The most important service the hospital provides for its community is, of course, patient care. *One of every eight people will receive hospital care this year!* Hospitals now do more for people than ever before. They are not dealwith merchandise but with human life. When a hospital has a human life at stake, it cannot and does not hold back because of cost. Would you, as that patient, have it otherwise?

The non-profit community hospitals are governed by voluntary community leaders. These men and women are legally and morally responsible for the operation of the hospital in the interests of the community. These trustees

receive no compensation for their time and effort. The trustee's job is to protect the health of the individual and the community. And, the community is served in many ways: poison control centers, diabetes detection centers, alcohol study clinics, prenatal instructions, and emergency services, available 24 hours a day, every day in the year.

By stressing the hospital community services, physicians can help the public to understand hospital costs.

Hospitals and the medical profession need an informed public.

The hospitals of New Jersey ask that the physicians of New Jersey assist in explaining the cost of hospital care so that America's great system of hospital and medical care can continue.

In interpreting hospital costs to a patient, remember:

1. Payroll costs up (2 plus employees per patient; two-thirds of total expense is payroll, more skilled personnel, improved personnel policies)
2. Cost of living up for hospitals also
3. Can't automate like industry (people serving people, inescapably personal care)
4. New, better equipment due to medical advances requiring more highly skilled personnel
5. Shorter length of stay (more complex tests, treatment, equipment)
6. Population (longer life span, more obstetrical care, higher over-65 utilization)
7. Twenty-four hours a day, seven days a week operation, (always ready and staffed for an emergency)
8. Your hospital bill is a bill for health and longer life.

46 South Clinton Avenue

Antibiotic Certification

"The Food and Drug Administration certifies five antibiotics and insulin. These precautions were first applied to penicillin during World War II. Even though these antibiotics have been produced in pure crystalline form for years by firms of unquestioned competence, the F.D.A. has stopped certifying only one form of one antibiotic. As a result, reliable manufacturers with years of experience are still being forced to add to their costs by paying fees to support this certification program. During fiscal 1959, this covered only six drugs but it cost more than 1.2 million dollars. That same year, the F.D.A. used less than 9 million dollars for all its other enforcement activities." — Elmer B. Vliet, Chairman of the Board, Abbott Laboratories, to American Society of Oral Surgeons.

Hemolytic Streptococci and Smoking

In an investigation of the relation of smoking to the frequency of beta-hemolytic streptococci from throat cultures, thousands of throat swabbings were analyzed. This study was reported by Milton S. Saslaw and Murray M. Streitfeld (Am. J. Med. Sci., 237:754, June, 1959).

Beta streptococci were isolated from the throats of those who smoked nearly twice as often as from those of nonsmokers or of those who had previously smoked. This difference was statistically significant. No significant difference was found in titers of sera from smokers and nonsmokers in antistreptolysin 0 studies.

The greater incidence of the streptococci among smokers was thought to be due to an effect of the smoke products either on the streptococci or on the mucous membrane of the host.

Albert Minzter, M.D.

Elizabeth

Orchitis as a Complication of Coxsackie Virus Infection

Orchitis in an adult is not always due to mumps: it might be Bornholm Disease or some other manifestation of Coxsackie Virus.

Orchitis, as a clinical feature of Bornholm disease,* had been recognized even prior to the discovery [1] of the prototype Coxsackie virus in 1947. Since then, additional immunologic varieties have been separated into groups A and B. Five types of B and 25 of A have been distinguished antigenetically.[2] In 1950, group B virus was shown to cause pleurodynia* and in 1952 a group B virus was causally related to an epidemic myocarditis in the newborn. In 1951, Coxsackie group A virus was shown to cause herpangina. Since then, various clinical syndromes which overlap have been ascribed to group A and B viruses. In general, group A viruses produce illnesses which cause herpangina and aseptic meningitis and pericarditis on rare occasions. Group B frequently causes pleurodynia, aseptic meninigitis, myocarditis, pericarditis, and orchitis. These varieties of findings may occur in any combination.

Classification of Coxsackie viruses into group A and group B is based on the lesions produced by these agents when injected into suckling mice and hamsters. Group A produces a severe myositis resulting in muscle paralysis and on occasion causes poliomyelitis-like findings. B infection causes inflammatory reactions in fat, brain, pancreas, liver and heart tissues. In part, the lesion produced can be modified by the route of inoculation.[3] All five group types of B and many of group A are known to cause human disease.

In an outbreak [4] of 35 cases of Bornholm disease* in 1945, orchitis was seen in 12 of 30 male patients. It was always unilateral, affecting either side equally and accompanied by a febrile reaction. The orchitis cleared for the most part in two to six days. No oophoritis was seen among the women. A familial outbreak of Bornholm disease was reported [5] in 1952 involving the parents and three sons. The father and two boys had orchitis as a complication. The authors note that Bornholm disease should be considered in epididymo-orchitis of undetermined origin especially if the condition appears in epidemic form. Also, orchitis should be especially looked for during the second week of illness.

In a large outbreak [6] of Coxsackie virus in-

*Bornholm is an island in the Baltic Sea. The characteristic "transient" diaphragmatic spasm (epidemic pleurodynia or "devil's grip") is more or less endemic there, and the disorder is often called Bornholm Disease (not Bornholm's Disease) for this reason.

1. Daldorf, G. and Sickles, G. M.: *Science,* 108:61 (July 16) 1948.

2. Daldorf, G., Melnick, J. L. and Curnen, E. C.: *The Coxsackie Virus.* Philadelphia, 1959. Lippincott. Ed. 3.

3. Daldorf, G.: Journal of Experimental Medicine, 106:69 (January) 1957.

4. Jamieson, W. M. and Prinsley, D. M.: British Medical Journal, 2:49 (July 12) 1947.

5. Morrison, R. J. G. and Baird, J. P.: British Medical Journal, 1:198 (January 26) 1952.

6. Warm, J. F., Daves, J. B. M., Sanders, F. K. and Vizoso, A. D.: British Medical Journal, 1:1345 (June 20) 1953.

fection in England in 1951, the 227 cases included 31 adult males. Three of these 31 developed orchitis on the fourteenth and fifteenth days of illness. In two cases the orchitis was bilateral. It subsided after three to four days. Since then, numerous reports of Coxsackie virus infection have been made. Meningitis, pleurodynia, pericarditis, and myocarditis are generally given principal attention. In recent articles relatively less emphasis has been placed upon the findings of orchitis in this group of virus infections.

The present report deals with three cases seen recently which (although not proved etiologically) are associated with orchitis developing during the course of an illness, consistent with Coxsackie B virus infection. This emphasizes again the association of orchitis with such an infection. This report suggests that closer diagnostic studies should be made in patients with orchitis as a clinical feature of this infection.

CASE ONE

A 47-year old car salesman was admitted to a hospital because of testicular pain. Twenty days prior to admission, he had had fever, malaise, and generalized myalgia. He responded to symptomatic therapy and returned to work after about one week. However, ten days prior to admission, he developed discomfort in his lower rectum which seemed related to urination. This discomfort resembled symptoms previously noted during an episode of prostatitis. The patient had an increase in temperature and some general malaise. Because of a congenitally absent right kidney, a previous nephrostomy due to left renal lithiasis and a prior history of non-venereal prostatitis the patient was placed on chloramphenicol, 250 milligrams four times daily despite repeated normal urine examinations. He also complained of pain and tenderness in the right testicle. After a few days, the discomfort subsided and the pain shifted to the left testicle. This too subsided after a couple of days. The testicular pain again recurred, apparently related to increased physical activity.

Immediately prior to admission, an abdominal flat plate revealed no renal calculus. Four urine examinations were negative prior to admission to the hospital.

Examination on admission revealed an afebrile male, moderately uncomfortable because of a tender and painful left testicle. This was the only pertinent finding.

Laboratory studies on admission revealed no abnormal urinary findings on three specimens. Specific gravity ranged between 1.015 and 1.020 with no protein or sugar and only an occasional white blood cell on microscopic examination. The hemoglobin varied between 12.2 and 15.8 Grams. with a white blood count ranging between 9,700 to 13,000 and a normal differential count. Blood chemistries included acid and alkaline phosphatase, cholesterol, glucose, blood urea nitrogen, serum transaminase, uric acid, calcium, phosphorus, and chloride examination which were all within normal limits. A urine culture grew Staphylococcus albus and an alpha Streptococcus. After five days, the patient became asymptomatic and was discharged. Reported as "negative" were x-ray films of the lumbo-sacral spine and chest. An intravenous pyelogram revealed hypertrophy and moderate hydronephrosis of the left kidney and non-visualization of the right kidney.

CASE TWO

A 29-year old man complained of shaking chills, high fever, chest pains (suggestively pleuritic in nature) and a moderate nonproductive cough. He had a flushed face and looked acutely ill. Head, eyes, ears, and throat were within normal limits. No skin rash was noted nor was there any significant adenopathy. Heart and lungs were not remarkable and the liver and spleen were not palpable.

It was thought that he probably had a pneumonia and tetracycline 250 milligrams four times daily was started. X-ray later that day did not reveal pulmonary infiltration. He had a leucocyte count of 6900. Of these 58 per cent were polymorphonuclears; 11 per cent bands; 22 per cent lymphoëytes, 7 per cent monocytes and 2 per cent eosinophiles.

After three days, chest pain persisted and he exhibited no significant clinical improvement. He then suffered from severe frontal headache which radiated to the occipital area and was aggravated by movements of the head. The following day (one day prior to admission to the hospital) he developed posterior neck pain on extreme flexion of the head with no associated nuchal rigidity. He entered the hospital on the seventh day of his illness. On admission, he had 5900 white blood cells. Of these 46 per cent were polymorphonuclears; 30 per cent were lymphocytes; 13 per cent monocytes, and 1 per cent eosinophiles. He had a normal urinalysis and a sedimentation rate of 70 Westergren. Three blood cultures were negative as was a urine culture. At spinal tap, pressure was normal with 41 cells per cubic millimeter, all lymphocytes. The protein was 26 milligrams per cent and glucose 70 milligrams per cent. Intradermal intermediate PPD was negative and chest x-ray was not remarkable. A heterophile and cold agglutination examination were negative as were serologic studies for syphilis on blood and spinal fluid. Electrocardiogram revealed an incomplete right bundle branch block.

Two days after admission and ten days after the onset of illness, he developed bilateral testicular pain without associated swelling. He had abdominal pains with nausea and vomiting which lasted two days. Serum amylase was 112 units. The testicular complaints were treated symptomatically and subsided after four days. The patient gradually improved and was discharged ten days after admission, most of his acute symptoms having subsided. Postviral asthenia persisted for 3½ weeks.

Interestingly, this patient's child was being studied by the pediatrician for a fever of unknown origin, one week prior to his own illness. The patient's sister-in-law developed an acute febrile illness with myalgia, pleurodynia and signs of meningitis with headache eight days after the patient's hospital admission. This sister-in-law's child had an illness like that of the patient's child ten days before the patient's hospital admission.

This patient lived only three houses away from the patient described in Case One. Case Two suggested the diagnosis in Case One, which was not considered during the course of his illness.

CASE THREE

A 35-year old man had symptoms of fever, myalgia (including non-pleuritic chest pains) and headache with associated nasal congestion. He had some pharyngeal injection but the remainder of the examination including head, chest, heart, and abdomen was not remarkable. No rash or adenopathy were noted.

Eight days later, after having become asymptomatic and afebrile, he suddenly developed a temperature of 101 orally with right testicular pain without associated swelling. The pain was moderately severe and codeine with bed rest were recommended. After four days the symptoms subsided.

Stool specimens studied by New Jersey State Department of Health Laboratories following orchitis yielded Coxsackie B_4 virus. Serologic studies revealed no mumps antigen.

In all these cases, there was no significant testicular swelling although there was considerable pain and tenderness. In two cases the testicles were involved bilaterally; in one case, unilaterally at different times. After the orchitis subsided there was no testicular atrophy in any of them. In the short period of follow-up (which has extended about 12 months) there have been no additional pregnancies in any of the families; but there has not been any effort to effect an increase in the family size by any of the patients.

Serologic studies for Coxsackie virus are not done at the New Jersey State Department of Health Laboratories. Studies on stool specimens for Coxsackie virus are, however, performed by this laboratory.

Coxsackie virus disease should be considered with any patient with chest pain and cough, fever, pericarditis, aseptic meningitis, or orchitis or a combination of these. This is especially important if there is an outbreak of an epidemic viral disease. Also to be considered are mumps (if meningo-encephalitis and orchitis co-exist); herpetic gingivo-stomatitis and herpangina. Pleurodynia may simulate pleurisy, pneumonia, pericarditis, and coronary occlusion. Aseptic meningitis could be caused by a variety of viral agents including Coxsackie, mumps, lymphocytic choreomeningitis, and non-paralytic poliomyelitis.[2]

DIAGNOSTIC CRITERIA

THE strict diagnostic criteria for the diagnosis of Coxsackie virus infection are:[7]

1. A compatible syndrome of questionable origin not associated with a known pathogenic organism.
2. An antibody response to Coxsackie virus of four-fold or greater between acute and convalescent serum specimens.
3. A Coxsackie virus should be recovered from the patient.

Admittedly these criteria have not been met in the cases noted. However, at the time these cases were seen, a significant Coxsackie virus epidemic was reported in this area by the New Jersey State Department of Health. The clinical picture which all the patients presented was consistent with the diagnosis of Coxsackie virus infection.

SUMMARY

1. A brief review of Coxsackie virus infection is offered.

7. Fifer, W. R.: Minnesota Medicine, 43:655 (October) 1960.

2. Three case histories are presented of patients who developed orchitis during the course of a virus disease which was consistent with the clinical picture of Coxsackie virus infection.

3. The frequency with which orchitis is associated with Coxsackie disease is noted and emphasized.

4. In all cases where undiagnosed orchitis is encountered diagnostic studies for Coxsackie virus should be included.

350 Irvington Avenue

Hospital Medication Errors

That medication error frequently results from illegal dispensing is brought out by leaders among America's 6,000 hospital pharmacists.

Sister M. Gerald, chief pharmacist at St. Joseph's hospital in Hamilton, Ontario, informed a meeting of hospital administrators that "an alarming increase" has caused medication error to spurt ahead of "sponges left in patients during surgery as the leading cause of hospital accidents. Sponges have dropped to fifth place."

Sister Emmanuel, pharmacy director at Providence Hospital in Detroit, who believes that a possible trend of automatic drug dispensing systems in hospitals will raise the odds toward more mistakes, writes: "We cannot expect the nursing personnel to take on the role of the pharmacist. It would be unjust to expect nurses to pick up medication errors (made by physicians or created in transcribing doctors' orders) when we pharmacists ourselves are continually struggling to keep up with the latest drugs, dosage forms and strengths."

Dr. George Archambault, an attorney and pharmacist who is president of the American Pharmaceutical Association, expresses it bluntly: "Each time a nurse goes to a pharmacy and identifies, selects, dispenses or labels medication, she is breaking the law. Nursing statutes specifically restrict the nurse to administering medication. You may say that nurses don't play pharmacist very often. But that is not so. They do."

—April 1963 *Medicine at Work* (Washington 5, D.C.)

Withdrawal Therapy for Reformed Smokers*

Experience of 6,000 patients treated in six tobacco withdrawal clinics in Stockholm, Sweden, over a period of six years showed 97 per cent good results with a complex of medical and psycho-therapy during an intensive 10-day initial treatment.

Education of the patient about his smoking habits is the most important aspect of the program. A manual on how to stop smoking is provided and an intensive discussion with the patient inaugurates the treatment, covering amount of smoking and reasons for wanting to stop, psychology of smoking, effects of nicotine and other tobacco constituents and principles of therapy to be pursued

Injections of nicotine or nicotine-like drugs, such as lobeline hydrochloride, are administered to produce nicotine saturation and reduce craving. An anticholinergic agent is given to avert hunger associated with withdrawal.

After 10 days of treatment, 75 per cent of patients had stopped smoking; 21 per cent had reduced smoking by three quarters. After six months, 95 per cent were satisfied with results; 50 per cent were total abstainers, and of the other half, those who had relapsed were smoking a few cigarettes or had shifted to pipe or cigar. Among reported improvements were: increased working capacity, coughing alleviated, improved senses of smell and taste.

Clinical tests after treatment revealed: easier breathing, decreased heart rate, greater ease in performing heart and pulmonary function tests. These were compatible with patient's subjective feeling of well-being.

*Abstracted from Ejrup, Borje: British Columbia Medical Journal, 2:441 (April 1960).

Myrtle Fish Thompson, B.A., R.M.T.

Cedar Grove

Therapy Through Music and the Arts*

Music and the other arts constitute a powerful, but seldom used tool in the treatment of people with emotional disorders. Overbrook's nationally-known and unique program in this area is here explained by the one chiefly responsible for it.

An unusual venture in the use of the arts in its rehabilitation program has developed during the last dozen years at the Essex County Overbrook Hospital. Emphasis is placed on the creative aspects of participation in music, dance, drama, painting and sculpture and the visual arts. This is an autonomous department with formal Civil Service status, and approved title and job specifications. All this department's activities are structured to stimulate interest, help improve concentration and coordination, build feelings of self-worth, and challenge initiative and self-expression. Easier sociability, adjustments to the disciplines which the group or the activity demand, and improved attitudes are potential healthy by-products. Something to think about, and to do, with time, rather than dwelling too much on personal problems and deemed injustices; something to get up for in the inevitable new day, rather than marking time in inactivity and resentment. These are antidotes to feelings of hostility toward the hospital or other patients, and to feelings of rejection by family or of exclusion from what is going on in the world outside.

These goals are shared by all constructive occupation in a rehabilitation program. But the arts offer a unique opportunity to experience (alone, or to share in an experience of beauty with others) without feelings of self-consciousness. They allow one to know the joy of being uplifted, or deeply moved by artistic expression, whatever the art form. Popular music, modern dance, and some extreme of contemporary visual art may result in "being sent" by the experience, as the vernacular has it. Whether one only touches the fringes of esthetics as listener or observer, or moves more deeply into a reaction through personal participation there are tremendous potentials in these tools for therapy, which only now are beginning to be utilized. At the least, under the safe term "self-expression," they are sublimations permitted by society. At best they bring recognition within the hospital community, as well as satisfaction to the "doer" regardless of the artistic evaluation of his product. For artist, or amateur they satisfy the somewhat nebulously understood but vital human urge toward creative expression.

The arts can communicate meaning without need of words. We share in this creativity because not only is there in us the innate yearning for expression, but a need for sharing our feelings with others. As we want other eyes, ears and minds open to what *we* are saying, so we are drawn to acknowledgment and appreciation of what *others* are feeling and meaning. We can share this in spite of language

*This work is from the Essex County Overbrook Hospital, where Mrs. Thompson is Director of Music and Creative Art Therapy.

barriers and political and philosophical differences, as witness the good-will aspects of international tours by actors, musicians, and dancers, and the interest-provoking exchange of paintings, sculpture, and musical composition. Improved communication and better understanding come out of such artistic exchanges even when bitter controversy exists in ideologies.

Considering their powerful force for aiding self-expression and communication, it is strange that their professional use as ancillary tools has been so long delayed. That this is so is no more the fault of medicine, which must insist on validation, than of the arts themselves, which—aware of their own strengths and values—have been late in perfecting suitable technics.

Some of the present development of arts in rehabilitation has grown out of wars. Each war brought on new waves of enthusiasm for carrying entertainment and participation in cultural activities to Servicemen. Perhaps because music, even when not the main program content has served importantly in a supportive or accompaniment role to drama and dance, it became the most-used of the art forms, and the first of these to attain professional status in the therapy field. But others are following fast on this trail. A magazine is now published called *Art Therapy*. Photographs and stories about art studios in hospitals are beginning to appear in magazines. The press brings increasing report of dance therapy, and of plays written and produced by patients. The arts are on the march! And one of the broadest programs in the nation is the one at a County hospital, in one of the states small in size, but large in cultural appreciation.†

Some comment should be made on the title of Overbrook's Department of Music and Creative Art Therapies. This label does present contradictions since music itself *is a* creative art. The explanation stems from three facts: *first*, that this was previously a Music Therapy Department for several years; *second*, that music activities still make up the larger part of the program; and *third*, because music is the only one of the arts which has established itself with professional recognition in therapy. This is partly due to its national organization, (The National Association for Music Therapy, Inc.) which publishes a quarterly magazine and an annual year book, both widely disseminated; also because there is now professional registration of music therapists, (RMT-Registered Music Therapist); and finally because the academic goal of a baccaluareate degree in Music Therapy has been realized, (BMT—Bachelor of Music Therapy or BM—Bachelor of Music or BME—Bachelor of Music Education, the latter two with majors in music therapy.

†This is no time for modesty; the author means New Jersey.

MUSIC CAME FIRST

OVERBROOK has considerable—and intimate—identification with national developments in music therapy. In 1950, in New York City, when the music therapy association was formed this hospital already had an active music therapy department. Indeed, the then superintendent of our Essex County Hospital, Dr. Samuel W. Hamilton, was the keynote speaker for therapeutic uses of music at a national convention of music teachers. Since the founding of this professional organization, Overbrook has been in the forefront of music therapy developments. It has reflected the growth of the national movement in its own rapidly growing music therapy program, and also initiated one of the earliest clinical training centers in the country in this field.

Why did music, in therapy, grow more rapidly than the other arts? One reason was because most hospitals use some form of music, whether labeled a therapy tool or not. This may be only for church services; it may be only for jam sessions. It may be to satisfy the urge to perform of a few talented patients; or it may be used only for large groups, where, with little emphasis on skill, but much on release, many patients can be involved in participation. It may be for parties, it may be for dances—a band, an orchestra, choral groups, or elaborate shows. Or where there are few music facilities, community volunteers,

entertaining on the wards, may represent the major part of a program. Every institution has radio and television, and usually a record player. Listeners, performers, learners; classical and popular music; instrumental and vocal; individual and group—so runs the broad gamut! In any "long term" hospital, a busy music therapy department may find itself running an entertainment bureau, as well as a music school, to say nothing of serving in the "ministry of music," which is the new terminology for music used with religious services.

There are other stronger though less tangible reasons which relate to the physiologic and emotional reactions of people to the elements of music itself. Civilizations long before ours have used its powerful elements of rhythm and volume changes to incite or to tranquilize; and its softly persuasive potentials of melody, and associative content to play on feelings and to influence moods. Educators have known how to use the disciplinary values, and the stimulus toward achievement, of music study with professional performance goals. Endless gifted amateurs know the joys of performance without. The phrase "music is a universal language" is not outmoded. The usefulness of music for nonverbal communication and self-satisfaction continues to be recognized by many cultures. This is particularly true of its limitless reaches in our present age of recording and broadcasting, touching not only the many who perform, but the countless thousands of listeners and reactors. The extent of the use of music, and of its impact on our society are reflected not only in this mass use of records, television and radio, but also by the astonishing growth of community concerts by touring, or locally trained units, which permeate suburban, urban and rural areas throughout the country. One national organization of music teachers alone numbers half a million members; and there are others almost as large. The tremendous size of marching bands in Western colleges are matched only by the ubiquitous, city-supported symphony or opera groups in the "grass roots" development of American music. Such a growth was bound to be directed, in time, to exploration of its general therapeutic effect.

THE OTHER ARTS

EXPANSION into other arts was a natural development which grew out of such music projects as shows, skits, and special entertainments which most hospitals feature seasonally. These utilized artistic talents other than musical, and afforded satisfaction and recognition to the patients involved. Scenery, posters, program illustration, and costume design put patients to work sketching and painting as needed on special occasions. Now these stimulating projects are one part, only, of the total art work carried on in daily painting classes. In the same way theatrical props, formerly presented occasional demands on the ingenuity of a few people who worked easily with their hands. Now they are projects of groups who work regularly in the sculpture room with clay and plaster in a daily climate of creativity. Here the work of one often inspires another, artistically, or leads to conversation and discussions on common interests. The work is three-dimensional application of flat-plane pictures, or copies of other sculpture, or sometimes purely creative concepts. The latter are not infrequent, and are particularly revealing in their implications. Many of these are abstract or impressionistic in style. Molds and forms are not used except for preserving individual designs. Ceramics are avoided since this is already a thriving activity in the Occupational Therapy Department.

Although a great deal of the work of painting and sculpturing classes consists of copying other art, the choice of what pictures or objects to copy is the individual's; and *how* he does it is peculiarly and satisfyingly his own. Life-models, often chosen by the patients, are sometimes used, or still-life compositions which may be arranged by patients or staff. Six people painting or sculpturing the same composition will each say something different. Guidance and instruction are proffered but not urged. Those wishing to paint

outdoors may choose their own subjects. Semi-annual exhibits are open to patients, families, and community.

With even greater ease, dance forms and dramatics were incorporated in the total program. From occasional performance projects to regularly scheduled activities was a simple transition. Because these activities encourage socialization, self-expression, and feelings of security, they inevitably earn support from administrators in a rehabilitation framework.

Daily relaxation exercises to music now start off the day for all patients in the program, whatever their special interest, unless contraindicated for physical or behavioral reasons. Weekly or biweekly formal dance instruction increases social ease. Folk dancing breaks down barriers, and is invigorating. Modern creative dance groups stimulate imagination and release emotional tensions in a socially acceptable way. The more dynamic technics of "dance therapy" are restricted to the times a leader is available skilled in relating dance movements to body awareness and to feelings of self-worth; and equally skilled in handling personal relationships and psychiatric implications.

Formerly dramatics and play-acting meant only skit or show times. Now groups meet daily to explore words, sounds, and special technics of vocal and emotional production and control. Patients are encouraged to improvise, to act out feelings, or create emotional reactions which they then discuss for better self-understanding. Or they may use excerpts from play-reading material, or poetry, for esthetic enjoyment only, or for improving speech or communicating ideas.

ENTER THE PATIENT

Usually patients of like character are grouped together. Thus, we have a "receptive alert" class; a slower more reserved, somewhat self-conscious group; and a young adolescent "problem" class. The latter group has an over-abundance of energy and unconsciously is seeking ways of accepting discipline without losing status. These young people need recognition. They accept guidance only if it is not forced upon them. With them, all art forms may be used; and the leader may end up more exhausted than the class. The slower-moving, older class may use written material which is not too threatening in its demands or content. The alert older group welcomes more difficult assignments. They find enjoyment in memorizing, play-acting, improvising, and working without script. Occasionally this group puts on a short play with costumes and scenery, or even writes one. One complete two-hour show at Overbrook used original music and lyrics by patients and personnel.

By offering so many different ways of self-expression, a department of combined arts can allow concentration in one form, but yet offer a healthy spread of interests. This parallels the choices met outside the hospital, and bridges the gap from what one may have done in the past—or wishes one had, to what he may do—or thinks he will want to do, in the future. This is not meant vocationally, but avocationally, which also parallels cultural developments in the community to which he will return. It opens new vistas to the patient for knowing the world of arts, and for trying his own capacities. Even the few who hold back and remain peripheral, function passively as lookers-on. Some of these gradually move into participation. But for the many, the demands on initiative and creativity make the total program challenging and rewarding in a more positive way.

Inter-involvement makes for excellent morale through group achievement. Free moving from one activity to another, and applying oneself in each make for easier adjustment to work habits through learning to use leisure time constructively. A patient plans his practice period on an instrument, or his time in the sculpturing room, for example, to leave him free for the group activity, or activities he favors. Having these activities near each other, and on a co-ordinated schedule, offers constant exposure to new interests, which in turn conditions him to the pace outside.

Unless a patient is absorbed to a healthy degree in some one activity, or has shown a marked spread of interests, we prefer to see him assigned part-time to another department. While certain seasonal pressures necessitate unusual time and energy demands, on occasion, the general policy of the Department is to synchronize activities so patients both work and play, and have variety and choice, thus approximating conditions they will meet later.

DEPARTMENTAL ORGANIZATION

IN MANY hospitals,† Music is a section of Occupational Therapy, Special Services, or Recreational Therapy. At Overbrook it is a separate department. One advantage of this autonomous arrangement is this. A teacher in the art fields or a professional artist has usually started his specialty training early in life, and would not have taken four or five years of his training time for a general basic course in the activity therapies. His therapeutic training is likely to be superimposed *later* on his art specialty, often because of conviction that the latter has uses for improving health in mind or body. Perhaps at college he saw the suitability of his special talent for work in therapy, or he may have been drawn by strong personal drives towards work with people and so has combined the two in his baccalaureate training. Those who work at less specialized skill levels find it difficult (even with their fine academic training in dynamics and psychology) to use the art forms as freely as the professional.

Both therapist and patient will be stimulated and gain additional satisfaction if creative aspects of art forms are emphasized, and if freedom is granted to explore all ways of expression unique to each. Without these approaches the activity may become static and sterile. For the patient who is to work with him it is often the driving force of the therapist's special talent and obvious satisfaction in it that will capture his own interest, and perhaps touch off a kindred spark. At least he gains a glimpse, and often a growing appreciation through the feeling communicated.

One cannot draw clear-cut lines between what in an activity is recreational, what is uniquely educational and what is good occupational therapy. Study in any art form belongs in the area of education, but it often is also absorbingly healthy occupation, and certainly it is diversion to many. Who can say that recreational projects in music, or dancing, or dramatic activities, or painting, or sculpture, are not equally good occupational therapy, and in many ways educational therapy as well? All have similar goals which each of the arts in therapy shares: they stimulate interest and imagination, encourage application, and use energy productively.

DOES IT WORK?

THE criterion for judging the efficacy of any organizational structure is in practicability. Does it work? By being a separate unit it was possible for the Music Therapy Department at Overbrook freely to explore many uses of music. When functional uses of allied forms in the Department's activities focussed attention on their potential further usefulness for patients, it was an easy matter with administrative support, to apply the same empirical procedures and absorb them in one over-all creative arts program.

All this costs money and money is needed for many different kinds of things in hospitals. Why then this icing-on-the-cake when there is always bread to be bought? (And beds--and ovens-and buildings-and medication). One very practical reason is that there were special funds ear-marked for patient welfare and recreation on which routine running expenses and supplies for this kind of leisure-time activity could call. But any activity program must prove its justification beyond that point. The taxpayer rightly demands reasonable return in public welfare on any further investment.

The modern philosophy of patient care now reinforces the rationale: A hospital must be concerned not only with health but with hu-

man happiness. Mankind has three basic needs: to be busy, to belong, to be loved. An individual feels his best when doing his best, not only in his job but in his leisure time. Medicine joins philosophy and throws down its gauntlet: We have increased your life-span. Now what will you do with it?

AS OTHERS SEE IT

THE psychologist says: "We must be permissive. The patient must choose. This is the day of the balanced diet. Even school children understand the part vitamins play in healthy physical tone. So also for emotional tone we must have balance of work and play.

Adds the sociologist: Life in a hospital must emphasize the normal and should approximate conditions in the community outside. Thus, we can help the patient bridge the gap between the two.

The clergyman insists: We must help patients find for themselves a way of living and thinking which will make them stronger to withstand stress, and richer in personal fulfillment.

The psychiatrist agrees: Medication, yes, but *privileges* . . . patients must have privileges, to grow.

And all the activity therapists together: Let work be one obligation only. Relaxation has been added to the rights of man. Play—make things with your hands—have fun! Let yourself go. Even fun is now legitimate.

Fortified by such sound arguments, a creative arts program can feel assured that it will be one of the trimmings which is a sound investment in good health, and can reassure Administration that it will bring equally sound returns in good public relations. The defense rests.

A final "why": Why *Essex* County? Why here rather than in many another county or State hospital? Because it is a county small in size, but large in population and in its civic pride. Families are close and visit often. It is urban, suburban, and rural. There is a wide gamut of tastes and interests; but talent knows no one section nor class distinction. Relatives have faith in its care so that they do not hesitate to use it when in trouble. It is a county of wealth yet with many poor. It is a county of many opportunities and with many cultural activities going on for all kinds of groups. As with the county so with our patients. The soil was ripe for such a department.

ADMINISTRATIVE PROBLEMS

THE nurturing since has been continuous.

Hard work, yes; imagination, organization, and many times, courage, all these were needed. But without administrative and medical support this development could not have been realized. The doctors, through their ever-increasing referrals, and their accessibility to contact for advice have been very helpful. Unstinting support and interest have been given from the start by the governing body of our county, the uniquely named Board of Chosen Freeholders. Although its personnel changes from time to time it has remained steadfastly dedicated to providing as many advantages for "the good life" for patients as sound principles of management allow.

To three superintendents—all during the music therapy period—this Department is deeply indebted for the opportunity and privilege their support has made possible. Dr. Samuel W. Hamilton under whose endorsement the Music Therapy Department was begun in 1948 considered music a powerful tool to bolster the patients' native drive toward health. He "dreamed dreams" and brought to fruition many kinds of privileges for his patients, among them music therapy. His interest in music therapy stemmed from an earlier association, while in the National Committee for Mental Hygiene, with Dr. van de Wall's studies on the uses of music in correctional institutions of Pennsylvania, in 1921.

Dr. Joseph G. Sutton, who followed Dr. Hamilton in 1950, was interested in all expressive art forms and was himself an amateur actor of no mean talent. After some initial

skepticism as to the value of such a program he became a staunch advocate of the wide uses of music at Overbrook, and laid the groundwork for later expansion to the other arts. Then came Dr. Henry A. Davidson, superintendent since 1957, who is sensitive to all advances in treatment and sensitive to new ideas.‡

Without these three men there might well have been frustration and failure. No job can be done in any activity field unless three requisites are made available: adequate place to work, adequate equipment to work with, and adequate personnel to implement a program. They have supplied these three basic adequacies generously through the years and have watched new developments with interest. With such support there is no excuse for a good job not being done.

We must look to the future to verify theories and improve technics. We must pay greater attention to individual patients if we are to realize the therapeutic potentials of the arts. This is hard to do while covering so much ground diversionally for the institution. Yet any hospital which supports such a department should feel free to call on it for those specialties which promote a pleasant institutional climate. In spite of these demands, and in spite of increasingly large case loads and the grinding necessity for paper work we must not lose sight of the prime goal. The patient's problems, tendencies, and progress must be reported on and discussed with other therapists. Workers must be eager to continue to learn; they must be honest with patients and with themselves, feel respect for patients as people and sympathize with their problems without being emotionally involved. They should have buoyancy of spirit but composure in manner.

Professional writing, sharing experiences and technics with therapists, keeping up with developments in one's own and allied fields, helping establish high standards of training, and using pilot studies to serve toward finding answers rather than inflexibly holding back to "wait on" answers from others: these are ways in which therapists increase their effectiveness in the arts.

CONCLUSION

A LARGE and friendly hospital, in a busy county, not too busy to care about its people and their needs, has sponsored a unique program which is matched in few places. A trail may well have been blazed here for the arts in therapy which other public institutions will wish to follow. Meantime, we are privileged to carry the torch, at Overbrook, and dedicated to fan into flame the creative urge where ever we find it.

‡The rest of this paragraph was deleted by the editor.

1 Fairview Avenue

Growing Pains Are Back in Fashion

Maybe grandma is right. "Growing pains?" Could be, says M. J. Shapiro, a California pediatrician in the March 25, 1961 Journal of the American Medical Association. Nocturnal muscular pains in children are common and do not necessarily indicate organic disease, he said. "Such nocturnal pains occur in normal healthy children, may possibly be due to normal growth but more probably to violent play during the previous day; massage and an aspirin tablet give almost immediate relief. The patient awakes almost completely relieved." Nonrheumatic leg pains (growing pains) occur at end of day or soon after falling asleep with the child free of pain in the morning. The pains occur in the muscles of thighs and legs; there is no pain on motion; the child is vague in pointing out site of pain; pain in the upper extremities is unusual.

Jerome Abrams, M.D.
Frank C. Dresdale, M.D.
Plainfield

Elmer C. Bartels, M.D.
Boston

Successful Pregnancy After Treatment of Cushing's Syndrome*

Cushing's syndrome need not bar subsequent pregnancy. The management of that pregnancy however, takes good clinical teamwork.

A patient who had been subjected to a bilateral subtotal adrenalectomy for Cushing's syndrome recently completed a successful pregnancy under coordinated obstetrical and medical management. Only 15 such cases have previously been reported.

A 33-year old gravida 5, para 2, was first seen by the senior author during the sixth week of her fifth pregnancy. She had had a spontaneous abortion in 1953, and a duodenal ulcer in 1954. In April 1955, she noticed excessive weight gain and hirsuitism. She then had the stigmata of adrenal cortical hyperfunction.

A diagnosis of Cushing's syndrome was made and at the Lahey Clinic, a two-stage bilateral subtotal adrenalectomy was done. This included a total right adrenalectomy and removal of nine-tenths of the left adrenal gland. This was in July 1955. The pathologic diagnosis was adrenal hyperplasia. Signs and symptoms of Cushing's syndrome subsided and subsequent adrenal hypofunction was managed with substitutional therapy in the form of cortisone and excess salt.

Several months later she had a spontaneous abortion. A third pregnancy ended successfully in 1957. A fourth pregnancy terminated in a neonatal death of a premature infant in the spring of 1959. Both third and fourth pregnancies were complicated by signs and symptoms of threatened abortion during the 13th and 20th weeks respectively. In the fall of 1959 substitutional therapy was altered to include a more potent salt-retaining medication, fludrocortisone acetate.

At the time of the first antepartum examination of the fifth pregnancy (April 3, 1961), no abnormalities were noted other than healed lumbar incisions. Last normal mensis had begun on February 22nd, and uterine enlargement was consistent with a six-week pregnancy. Blood pressure was 90/60. Papanicolaou cytology disclosed an apparently adequate estrogen-progesterone balance. There was no evidence of malignancy. Dosages of cortisone (37.5 mg. to 62.5 mg. daily) and fludrocortisone acetate (0.5 mg. every second or third day) were regulated according to determination of blood pressure and weight gain.

During the eighth week of pregnancy (April 17) the patient complained of vaginal staining and a course of norethindrone (10 mg. daily) was instituted. Although cognizant of the possible virilizing effects of 19-nortestosterone derivatives upon a female fetus, it was felt that a 33-year old patient with three unsuccessful pregnancies and a serious endocrinopathy should receive all reasonable assistance during this fifth pregnancy. Colpocytology had disclosed no evidence of a progesterone deficiency; but it was decided to prescribe norethindrone (10 mg. daily) for the shortest possible period of time. Although vaginal staining had subsided quickly, the presence of intermittent abdominal "cramps" favored the continuation of the 10 milligrams daily dosage until the twelfth week of pregnancy when a satisfactory serum chorionic gonadotrophin level was reported.

The dosage of norethindrone was gradually reduced until it was discontinued completely at the fifteenth week of pregnancy. Throughout the remaining weeks of pregnancy the patient was examined alternately by obstetrician and internist.

At the expected date of confinement, labor began spontaneously. Delivery occurred within three

*Read October 12, 1962, before the American College of Obstetrics and Gynecologists.

hours. Meticulous pediatric examination of the healthy full-term female infant disclosed no evidence of virilization. The mother received 100 milligrams of cortisone on the day of delivery; dosage was gradually reduced to antepartum levels. Hemogram and serum electrolyte determinations were entirely within normal limits. Mother and baby were discharged from the hospital on the seventh post-partum day in good condition. The patient has continued to enjoy good health with the exception of minor gastro-intestinal disturbances.

REVIEW OF THE LITERATURE

THE fifteen patients who had completed successful pregnancies after total or subtotal adrenalectomy for Cushing's syndrome are presented in the table. The peak incidence of Cushing's syndrome in women is during the third and fourth decades.[1] The age-range in this series was 21 to 36. The patient described in the present report was 27 years old at the time of adrenalectomy. Four patients underwent total bilateral adrenalectomy. All four required postoperative substitutional steroid therapy. Steroid dosages were increased during the pregnancies. Most of the eleven patients who underwent subtotal adrenalectomy required no substitutional therapy during the postoperative period, even during pregnancy. There were three patients,[2,7,8] as well as the patient in the present report, requiring substitutional steroid therapy after subtotal adrenalectomy. Apparently the amount of adrenal tissue remaining was insufficient to support bodily function.

There were ten cases of adrenal hyperplasia and five of tumor (three adenomas[7,9,10] and two adenocarcinomas[7]). Two primigravidae,[6,7] ages 32 and 35, requiring substitutional steroid therapy during pregnancy, underwent elective cesarean section. Three patients[3,7] in the fourth decade of life, requiring no substitutional steroid therapy, were allowed to deliver normally.

COMMENT

PREGNANCY complicated by major endocrinopathies, whether the more common diabetes mellitus or the less common adrenal hypofunction, may be expected to respond to coordinated obstetrical and medical management. The pregnant patient with adrenal cortical hypofunction will find that the ingestion of fludrocortisone acetate every second or third day will be easier than consuming extra salt and much more convenient than taking buccal tablets of desoxycorticosterone. Frequent visits to the obstetrician and internist will permit careful observation of variations of weight and blood pressure, and thus facilitate control of dosages of cortisone and fludrocortisone.

The patient reported above presented the signs and symptoms of threatened abortion during the fifth pregnancy as well as during the four previous pregnancies. Despite treatment with a derivative of 19-nortestosterone during the weeks of organogenesis, virilization of the female fetus did *not* occur. None of the fifteen previously reported patients had received fludrocortisone acetate since it was not generally available prior to 1959. Pregnancy was essentially uneventful; labor and delivery proceeded rapidly without complication. The management of labor and delivery might be influenced by the presence of adrenal hypofunction to the extent that a long labor would prompt surgical interference somewhat sooner than if this endocrinopathy did not exist.

REVIEW OF FIFTEEN CASES OF SUCCESSFUL PREGNANCY AFTER TREATMENT OF CUSHING'S SYNDROME

Age	Author and Year		Operation
28	de Piava, *et al.*[10]	1951	RA†
32	Hunt & McConahey[3]	1953	SA-BL†
36	Hunt & McConahey[3]	1953	SA-BL†
35	Hunt & McConahey[3]	1953	TA†
33	Byron & Pearl[9]	1954	RA†
22	Hernberg[11]	1955	SA-BL†
32	Worner & Mathew[6]	1956	TA-BL†*
21	Moller[2]	1957	SA-BL†*
27	Schneider, *et al.*[5]	1957	TA-BL†*
23	Schneider, *et al.*[5]	1957	BL-TA†*
36	Tivenius[4]	1959	TA-BL†*
35	Greenblatt, *et al.*[7]	1959	TA†*
34	Greenblatt, *et al.*[7]	1959	TA-carcinoma
23	Greenblatt, *et al.*[7]	1959	TA-carcinoma
24	MacGregor, *et al.*[8]	1960	SA-BL†*

*Indicates postoperative substitutional therapy.
†RA: Removal of adenoma. SA: Subtotal adrenalectomy. TA: Total adrenalectomy. BL: Bilateral.

SUMMARY

1. A case of successful pregnancy after bilateral subtotal adrenalectomy for Cushing's syndrome is reported.

2. A brief review of fifteen similar cases from the literature is presented.

323 West Ninth Street

BIBLIOGRAPHY

1. Peterson, R. E.: Med. Sci., 7:411 (March 10, 1962).
2. Moller, H. J.: Acta Obstet. Gynec. Scand., 36:137 (1957).
3. Hunt, A. B. and McConahey, W. M.: Am. J. Obst. & Gynec., 66:970 (1953).
4. Tivenius, L.: Acta Med. Scand., 164:147 (1959).
5. Schneider, G. T. *et al.*: Obst. & Gynec., 10:437 (1957).
6. Worner, K. G. and Mathew, A. G.: J. Obstet. & Gynaec. Brit. Emp., 63:248 (1956).
7. Greenblatt, R. B., Scarpa-Smith, C. and Metts, J. C.: Fertil. & Steril., 10:323 (1959).
8. MacGregor, W. G., *et al.*: J. Obstet. & Gynaec. Brit. Emp., 67:465 (1960).
9. Byron, C. S. and Pearl, H.: Fertil. & Steril., 5:455 (1954).
10. de Piava, L. M., Lobo, J. I. and da Silva, A.M.: J. Clin. Endocrinol., 11:330 (1951).
11. Hernberg, C. A.: Duodecim., 71:206 (1955).

Absolute Safety Not Guaranteed

By its enactment of the Kefauver-Harris Act, Congress placed fearsome responsibilities on the Food and Drug Administration. Congress should follow through and provide FDA with the resources it needs to do its new job well. In the words of John T. Connor, President of Merck & Company—"It would be a senseless tragedy if this nation forfeited its leadership in drug progress, not for lack of discoveries, but because a regulatory agency could not keep pace" . . . But however well the FDA is armed by Congress with human and material resources, none of us should lose sight of the fact that the pathways of scientific researsh and development are uncertain ones at best, and that no rule or regulation or law can guarantee absolute safety whether in outer space or in the pharmaceutical laboratory or the hospital clinic.—Theodore G. Klumpp, M.D., President, Winthrop Laboratories, to Senate Appropriations Committee, April 4, 1963.

Emphysema and Smoking

In a preliminary report on a prospective five-year study of mortality from emphysema among 64,256 members of the Seventh Day Adventist (SDA) faith in California, essentially non-smokers, four deaths were recorded with emphysema as an "underlying cause" and 14 deaths with emphysema as a secondary cause among the 1,354 male deaths verified by death certificate. At concurrent California mortality rates for men, 22 emphysema deaths could have been expected instead of four and 51 instead of 14.

Among the 18 SDA men who died of emphysema directly or indirectly, the 10 whose smoking histories could be traced by questioning next of kin had long histories of smoking, primarily cigarettes. Other studies of this church group indicated that about 19.7 per cent of SDA men were at some time regular cigarette smokers.

The authors* conclude that other population variables do not explain the degree of differences in emphysema mortality demonstrated and that "smoking, particularly cigarettes, may indeed be an important differential factor related to the risk of mortality from pulmonary emphysema."

*Dysinger, P. W. *et al.*: Diseases of the Chest, 43:17 (January 1963).

William F. Haynes, Jr., M.D.

Princeton

The Danger of Multiple Vitamins Containing Folic Acid

Here is a case of "masked" pernicious anemia with symptoms similar to multiple cerebral thromboses.

Absence of a glycoprotein-like factor secreted by the normal gastric mucosa ("intrinsic factor") has resulted in a lack of proper absorption of vitamin B_{12} in pernicious anemia patients. Intrinsic factor has not yet been isolated, but it is believed to combine with vitamin B_{12}. This complex unites with an intestinal mucosal receptor by means of a calcium bond in the lower ileum, enabling the B_{12} to be absorbed. This makes possible the therapeutic response in pernicious anemia in relapse. The mechanism of release of B_{12} from the intrinsic factor is not yet known.[1]

In recent years, the literature has sporadically mentioned the danger of "shot-gun" therapy of anemias of unknown cause. There have been warnings against the use of multiple vitamin preparations containing folic acid in correcting anemias of unknown cause. To be sure, folic acid-containing compounds *will* correct the anemia of pernicious anemia (combined system disease), but it may allow or even hasten the development of the dorsal and lateral spinal cord degeneration.[2 to 9]

The case described below demonstrated the findings of progressively severe ataxia, weakness, fatigue, and subsequent right-sided hemiparesis. These symptoms occurred over a 10-month period, during which time the patient maintained a normal hemoglobin and hematocrit. The clinical picture was compatible with the diagnosis of multiple "small strokes." Her symptoms progressed despite two months of continuous anticoagulation therapy. The possibility of a "masked" pernicious anemia was considered when it was realized that the patient had been receiving a multiple vitamin preparation containing folic acid. Gastric achlorhydria and a positive Shilling test made the diagnosis. The remarkably rapid clinical response following B_{12} parenteral therapy is noteworthy.

A 67-year old woman complained of an unsteady gait and fatigue that appeared to be progressing over the past six months. Past history was unremarkable except for a subtotal thyroidectomy done six years previously for a toxic nodular goitre. She had been taking two grains of thyroid extract daily since then. She had noted some numbness and "pins and needles" in her hands and feet several years ago. That disappeared soon after receiving some injections from another physician.

She was a tired looking woman who walked with an unsteady gait and who frequently needed to hold on to a chair or lean on the wall to keep from falling. Deep tendon reflexes were hypoactive but equal. Motor and sensory function were unremarkable. Aside from moderate swaying while performing the Romberg test, the rest of her physical examination was normal. Hemoglobin was 13.5 Grams; white blood count 12,250 with a normal differential count; PBI 4.6 micrograms per cent; total cholesterol 264 mg. per cent. Chest x-ray, electrocardiogram, and urinalysis were normal. A multivitamin elixir* was prescribed.

*The preparation was tradenamed Lixatone®. A product of Ruffingtons (Worcester, Mass.) it contained liver fractions, choline, betaine, inositol, lysine, niacinimide, pantothenate, several vitamin B fractions and folic acid in suspension, 1½ micrograms per fluid ounce. In 1962, the folic acid was withdrawn from the formula, and at this time, Lixatone® does not contain any folic acid.

Five months later, her ataxia had become more severe. Noticeable slowing of mental acuity with concomitant slurring of speech had occurred. She was more apprehensive and depressed. She had fallen three times since her last visit. She had an obvious "drag" of her right leg. Increased deep tendon reflexes were present in the right leg with decreased motor strength in both right upper and lower extremities. Vibratory sensation was absent in both lower legs. The diagnosis of multiple "small strokes" (cerebral thromboses) was considered, and anticoagulation therapy was started. At this time, hemoglobin was 13 Grams; hematocrit 40 per cent, white blood count 6,350 with 69 per cent polymorphonuclears, 29 per cent lymphocytes, 2 per cent eosinophiles. Sedimentation rate was 17 (Wintrobe). Total bilirubin was 0.58 (direct 0.18). Blood urea nitrogen was 14 milligrams per cent, fasting blood sugar, 101 milligrams per cent. Blood group was A. Rh positive.

Her neurologic symptoms continued to progress despite two months of anticoagulation therapy. It was then discovered that folic acid had been present in her multiple vitamin elixir* and that she could be suffering from combined system disease. A "Diagnex-blue®" test failed to reveal gastric hydrochloric acid. A Shilling test was then performed in the usual manner, using radioactive B_{12} cobalt, and the 24-hour urine collection revealed 3 per cent excretion. After a repeat Shilling test (but with the addition of intrinsic factor) the 24-hour urine collection revealed a rise to 14.7 per cent radioactivity. This was considered to be diagnostic of pernicious anemia.

In addition to 1000 micrograms of B_{12} used as part of each Shilling test, the patient received an average of 500 micrograms of B_{12} every day for the next eight weeks and then 500 every week for the subsequent three months. Ten days following the institution of parenteral B_{12} therapy, she had almost completely re-established her normal gait, was more alert and cheerful, and had gained eight pounds in weight. Mental acuity had returned and the fatigue had greatly subsided. Vibratory sense had been restored, deep tendon reflexes were equal in her extremities, and her motor strength had returned to normal when she was seen again four months later. The only residual difficulty was some slight unsteadiness upon turning quickly. This was thought to have been to some degree due to generalized muscle and joint weakness.

Ribonucleic acid (RNA) is found in the cytoplasm and nucleolus of cells. Desoxy Ribose Nucleic acid (DNA) is found only in nuclei and chromosomes.

DNA must be present in adequate amounts when cells divide and chromosomes double.

Folic acid is concerned with the formation of DNA. Vitamin B_{12} is required for both DNA and RNA production. Folic acid is required for only DNA formation. Neural tissue contains a large amount of RNA. Treatment of pernicious anemia with folic acid alone, therefore, will *not* correct the neurologic lesions; on the contrary, it will allow them to progress.[2 to 6] Lear and Castle[7] noted a drop in serum vitamin B_{12} levels in 18 of 27 pernicious anemia patients treated with folic acid. The fall in the serum vitamin B_{12} levels has been correlated with the hematopoietic response.

Large doses of vitamin B_{12} in a folic acid-deficient patient (as large doses of folic acid in a vitamin B_{12} deficient patient) can produce a hematologic response. In each case, supraphysiologic doses of either vitamin will bring about a more efficient utilization or mobilization of the respective deficient vitamin. Folic acid treatment of a vitamin B_{12} deficiency tends to increase deoxyribotide synthesis leading to a hematologic response at the expense of diverting the remaining supply of vitamin B_{12} away from necessary neural tissue metabolism. With further depletion of vitamin B_{12} the neurologic symptoms progress.[10 to 14]

PATHOLOGY

MULTIPLE areas of degeneration of white matter of dorsal and lateral columns of the spinal cord are involved as well as small areas of focal necrosis in the brain.[15]

It was originally thought that the neurologic lesions of pernicious anemia were confined to the posterior and lateral columns of the spinal cord. Later work,[16] however, has shown that peripheral nerve degeneration also occurs.[17] This accounts in part for the numbness and "stocking" type impaired sensation and hyperesthesia of the soles of the feet. Spongy breakdown occurs in the area, followed by gliosis. The entire structure of the nerve fiber is also destroyed,[16] including the axon and myelin sheath.

With progression of the disease, position and vibratory senses decrease. The midthoracic region is the first area in the spinal cord that demyelinates. This is why changes appear in the legs before the arms. Deep tendon reflexes may be decreased or absent with hypotonia and flaccidity of the extremities or they may be hyperactive. A girdle-like sensation of "pins and needles" may be noted about the mid-

thorax early in the disease. Gradually the patient's hands become clumsy, due to diminished position sense. Lack of awareness of the exact position of the extremities leads to a broad-based gait with stiff-legged motions and ataxia.[16]

Mental symptoms are varied and often include confusion, loss of memory, vague apprehension, dullness, irritability, lack of concentrating power and depression. More serious mental changes (such as hallucinations, manical episodes and schizophrenic symptoms) are much less common. Factors that compound the confusion include anemia *per se,* as well as debilitating disease and mental changes of the older group in general, i.e., diabetes, generalized arteriosclerosis and osteoarthritis.[19]

Early and continuous treatment of pernicious anemia is needed to halt the progressive development of neurologic changes. Some workers [16] believe recovery of neurologic lesions may occur if the axis cylinders of the involved columns of the spinal cord have not disintegrated. Some [9] believe recovery is possible until extensor plantar responses or impaired vesicle function has occurred.

SUMMARY AND CONCLUSIONS

1. A case of combined system disease is presented. The patient presented with marked neurologic symptoms with no evident anemia. Previously she had been taking a multiple vitamin preparation containing folic acid. This clouded the diagnosis of pernicious anemia because the folic acid corrected the anemia but allowed the neurologic lesions to progress.

2. Although folic acid is being gradually removed from most multiple vitamin preparations, the danger of a "masked" pernicious anemia must constantly be kept in mind. This is especially true in the older patient who appears to be suffering from multiple "small strokes."

253 Witherspoon Street

A listing of 19 citations appears in the author's reprints.

Remember the Mastoid Scars?

And even these were the fortunate ones, despite the fact that they were to carry a disfigurement for life. Many died. Particularly if meningitis had set in before surgery.

You see very few mastoid scars around today—and, under 20 years of age, they are almost nonexistent.

But, not so many years ago (1934) it was a different story:

"No case of acute mastoiditis should be accepted for insurance unless the ear has healed up after operation and has remained so for at least six months."*

From insurance risk to a practically unknown entity in medicine is quite a record for the relatively few intervening years between then and now. The reasons are not hard to come by. Diagnostic technics have improved enormously, as has the quality of medical education. And, we submit, so has the quality of the medicines which have become available.

Yet, the value of independent drug research has been seriously challenged—research which has produced the chemotherapeutic compounds which make the *cure* of mastoiditis practically a routine, not even a worrisome, procedure. True, the cost may run as high as $15.00. Yet, ask the man who paid $1,000.00 for his mastoid scar which he would have preferred—if he had the choice.

*Asherson, N.: "Acute Otitis and Mastoiditis in General Practice." H. K. Lewis & Co., Ltd., London, 1934.

ROBERT J. RYAN, M.D.

Trenton

Primary Resection of Perforated Colonic Lesions*

If the patient can withstand the procedure, primary resection and primary anastomosis appears to be the best treatment for perforating lesions of the colon.

Case	Age	Diagnosis	Operation	Present Status
1	53	Perf. sigmoid diverticulitis	Rectosigmoid and ileum resection. Two primary anastomoses	Well
2	44	Carcinoma of sigmoid. Perf.	Resection of sigmoid with primary anastomosis	Well (9 months after surgery)
3	66	Perf. carcinoma of cecum	Right hemicolectomy. Ileotransversastomy	Died 6 months after surgery
4	58	Perf. sigmoid diverticulitis	Partial colectomy. Primary anastomosis.	Well (2 years after surgery)
5	66	Perf. sigmoid diverticulitis	Partial colectomy. Primary anastomosis.	Well (7 months after surgery)

PRESENTED here are five cases of perforated colonic lesions treated by primary resection and anastomosis. All were treated since December 1959 at the St. Francis Hospital in Trenton.

All patients were males.

Each of these had a tender mass, two in the right lower quadrant, three in the left lower quadrant. Each had an acute illness with distention. Only one had preoperative bowel antisepsis with neomycin and sulfathalidine. All received antibiotics postoperatively.

The most significant finding, it seems to me, was a mass in an acutely distended abdomen.

All five had primary partial colon resections with an open anastamotic technic. Inner chromic 00 catgut and outer 00 linen were used. No colonic or urinary fistulae developed. Soft cigarette drains were used in the gutters. All survived and were discharged to their homes.

COMMENT

THIS aggressive attack on perforated colon lesions [1] has been evolving over the past 20 years. Prior to this, drainage and bypass were the common procedures. The bypass was either ileotransversostomy with ascending colon tu-

*This work is from the surgical service at St. Francis Hospital, Trenton.

1. Donaldson, G. A.: New England Journal of Medicine, 285:201 (January, 1958).

mors; ileosigmoidostomy for transverse lesions, or a transverse colostomy for descending colon perforations. In one series of 179 cases,[2] these procedures were done in 108. During the evolution of the presented method, however, those who had a primary resection and anastomosis fared better than those whose disease process was allowed to remain.[2]

Selection of cases is crucial. All of our five cases were free of generalized peritonitis and were of good enough physical stamina to withstand the procedure. Interestingly, all five were male. In another larger series[3] of acute colonic perforations 91 of 93 were male. In that series[3] acute diverticulitis accounted for most cases and carcinoma was second. It is estimated[4] that three to four per cent of colonic carcinomas perforate spontaneously.

CONCLUSION

1. Early diagnosis of perforated colonic lesions with aggressive resection and primary anastomosis appears to be the treatment of choice in patients who can tolerate the procedure.

2. Absence of generalized peritonitis is important. Localized peritonitis is no contraindication.

3. Antibiotics postoperatively should be given.

2. Madden, J. L. and Tan, P. Y.: Surgery, Gynecology and Obstetrics, 113:646 (November, 1961).

3. Hill. J. T., Cruze, K. and Stevens, G. A.: The American Surgeon, 25:971 (December, 1959).

4. Cawkwell, W. I.: New Zealand Medical Journal. 54:187 (April, 1955).

717 Hamilton Avenue

Microbiology of Pharmacy Ointments

Fifty-seven different bulk ointments, representing the stock of a general medical and surgical hospital pharmacy, were examined at regular interva's. Aseptically secured samples were inoculated into thioglycollate and Sabouraud's media. Those cultures supporting growth were subcultured and the organism was identified. Those preparations consistently failing to show growth during the study were tested, for bacteriostasis or fungostasis, by inoculating the negative cultures with test organisms. Hydrophilic oin'ments showed greater contamination than hydrophobic preparations. Many ointments classified as having anti-microbial properties revealed a significant microflora. The hydrophobic, anti-microbial ointments showed the least evidence of contamination as a group. Under the conditions of the study, pharmacy ointments represented largely a potential, rather than a significant source for the contamination of wounds with pathogenic microorganisms.

G. A. Harmon, *et al.*: Archives of Dermatology, 85:510 (April, 1962).

Something "Evil" About Profits?

Men of vision and courage in our industry have undertaken risks which more often resulted in failure than in success. The reasonable rewards which provide the incentive for this activity are profits. Without them our industry could not operate as it does. The perverted sense of values which has been forced upon us in recent years draws the broad implication that because our industry is commercial we should be suspect; the word profits has been portrayed as having an evil connotation; most recently we have been depicted as an industry willing, for profit, to foist "unsafe" drugs upon an unsuspecting public. Nothing could be farther from the truth. We progress commercially only as we progress scientifically and only because we understand and fulfill our moral obligations to the public we serve.—Francis C. Brown, President, Schering Corporation, to the U.S. Food and Drug Administration, November 26, 1962.

Theodore S. Heineken, M.D.

Glen Ridge

Gastric Cooling

In the hands of trained personnel, apparatus for gastric cooling may save lives that might otherwise be lost to massive gastric or esophageal bleeding.

Managing the patient with upper gastrointestinal tract hemorrhage is a serious problem in every general hospital. The sooner the bleeding is controlled, the less likely the damage to the patient. In some cases the bleeding site is not known. This makes choice of therapy difficult. Too often a concurrent disease makes the risk for surgery prohibitive.

Nicoloff, *et al.*[1] have shown the effectiveness of gastric hypothermia* in the temporary control of massive upper gastrointestinal hemorrhage. If bleeding from a peptic ulcer could be changed from an emergency situation to an elective procedure, it would be easier to operate on the patient. Hemorrhage from esophageal varices shows promise of being controlled with gastric cooling.

The types of hemorrhage controlled by this method are shown in the table.[1]

Lesion	Patients	Shock	Control	Death from Hemorrhage
Esophageal ulcer	2	1	2	0
Esophageal varices	12	10	8	3
Gastric ulcer	9	7	7	2
Erosive ulcer	5	2	5	0
Duodenal ulcer	16	10	16	0
Steroid ulcer	5	4	3	2
Postoperative bleeding	19	13	12	6
Gastric carcinoma	4	4	2	2
Hemorrhagic dyscrasias	3	0	2	3
Totals	75	51	57	18

The technic* uses temperatures between 0 and +10 centigrade (between 32 and 50 Fahrenheit). It is administered for from 12 to 48 hours.[2] The hope is to retard chemical activity in the stomach and blood flow to the stomach by lowering intragastric temperatures. Under cooling, here is what happens:

1. It depresses the gastric secretion.
2. Depresses the pepsin formation. The pepsinogen granules accumulate within the chief cells of the stomach mucosa and they are released only after the treatment.
3. Depresses the blood flow to the stomach by 70 per cent, when temperature is maintained between 10 and 14 centigrade.
4. Vaso-constriction of blood vessels. It produces a decrease in circulating blood volume; a rise in large vessel hematocrit, and a decrease in plasma volume.

PRECAUTIONS

1. A mild laxative before treatment may be given with caution is constipated; because cooling slows peristalsis through the small bowel, causing temporary ileus.
2. Washing out all clots from bleeding in the stomach.

*The equipment may be obtained from Shampaine Industries of Union, N. J.; or from Swenko Research Company of Minneapolis; or from Armstrong Engineering Consultants of Butler, N. J. The latter apparatus is trade-named Cryocyle.

1. Nicoloff, D. M., *et al.*: Surgery, 114:495 (April 1962).

2. Wangensteen, Stephen: Personal communication to author.

3. Leave in nasal tube to stomach with suction.
4. Tests: Temperature, pulse, respiration.

   A. Observation of suction from nasal tube for control of bleeding (red, brown, black).
   B. Hematocrit, hemoglobin, blood volume and urea nitrogen.
   C. Stools for occult blood.
   D. Serum amylase and brom-sulfo-phthalein.
   E. Chest x-ray before and after (prolonged cooling may cause pneumonitis).
   F. Electrocardiogram (cooling may cause premature ventricular contractions).

5. For the first eight hours, the tissues are kept at 0 centigrade (32 F.). For the next two hours, the temperature may be kept at 10 degrees centigrade (50 F.). For 24 hours thereafter, the stomach and esophagus should be maintained at 15 centigrade which is 59 Fahrenheit. It is wise to leave the appartus* in for a while to be sure that the bleeding has stopped, but remove the liquid from the balloon.

6. The balloon is removed after the 600 cubic centimeters of circulating 25 per cent alcohol has been withdrawn. Then iced milk and cream may be administered through the other tube. Twelve hour feeding is advisable to prevent "rebound" due to release of pepsinogen granules within the chief cells of the gastric mucosa.

60 Glen Ridge Parkway

Drugs for Cuba

The list of drugs, medical supplies, and food for the Cuban prisoners' release takes on added significance with each new report about conditions on the island.

One source of information (the Cuban Student Directorate in Miami) summarizes the health picture this way: "Many epidemics of various diseases, high mortality among the population and especially the infant population, almost a total absence of medicines." The mortality rate rise is so evident that a communist physician, Dr. Baldor de la Vega, reported it in a Cuban magazine. He had the courage to write that epidemics of infectious hepatitis, mononucleosis, measles, chicken pox, and mumps cannot be arrested. Schools are closed for weeks at a time because of widespread childhood illness.

The major cause for this situation has been lack of drugs. Contaminated food and water, deficient sanitation including uncollected garbage, and malnutrition also add to the toll.

So, too, do inferior drugs manufactured locally and in other communist countries. According to the Cuban Student Directorate, an ineffective vaccine produced on the island failed to stem diphtheria in Havana. Russian-made oral vaccine reportedly caused fever, diarrhea, and even permanent paralysis among some Cuban children.

In this situation, a number of U. S. pharmaceutical manufacturers hope to insure that drugs donated for the prisoner exchange will be used to benefit the sick in Cuba and not in other countries. At least one company marked its packages so they can be identified if they show up elsewhere in barter for equipment intended to threaten—instead of save—lives.

—*Medicine at Work* (Washington 5. D.C.) April 1963.

No Detailmen in USSR

Too much time is wasted in pharmacies compounding prescriptions, and this is only because the physicians do not know about the pre-compounded drugs . . . Obviously, only very few general practitioners follow the literature in which the new drugs are described . . . On the other hand pharmacy employees do not inform physicians about existing drugs. They do not come to the polyclinic and do not promote the new pharmaceuticals.—*Meditsinskii Rabotnik* (Moscow), May 19, 1961.

BURTON M. COHEN, M.D.

Elizabeth

Lung Function Testing in the Doctor's Office*

For the cost of a portable electrocardiograph, you can set up in your own office a lung function testing station. Dr. Cohen suggests how to set it up and how to use it.

SIMPLIFIED technics and apparatus developed in the last 20 years have made office estimates of lung function a reality for the family doctor. A "lung station" can now be equipped for the cost of a portable electrocardiograph. It takes very little room. Comroe's *The Lung*[1] or Knowles' *Respiratory Physiology and its Clinical Application*[2] are valuable for their lucid presentation of the tests available, their interpretation and limitations. The encyclopedic *Handbook of Respiration* (Saunders, Philadelphia, 1958) includes helpful formulae and tabulations.

A meticulous history and physical examination are the initial steps in testing lung function. The physician should classify the breathlessness from the history of the symptom and the circumstances of its development. Particularly helpful are Fletcher's criteria listed below. These will be found detailed in the Proceedings of the Royal Society of Medicine (United Kingdom) 45:577 (1952). Fletcher suggests five grades of breathlessness as follows:

Grade 1. Performance on walking and climbing hills and stairs as good as that of other persons of similar age and build.

Grade 2. Normal performance on walking but inability to keep up with others on hills or stairs.

Grade 3. Ability to walk a mile or more on the level at own speed, but inability to keep up with others.

Grade 4. Inability to walk more than 100 yards on the level without a rest.

Grade 5. Breathlessness on talking or undressing and inability to leave the house.

A fluoroscope will also be helpful in assessing respiratory muscle patterns and the mechanics of breathing and may disclose uneven air distribution and trapping of air, as well as specific chest pathology. Inspiratory "sniff" testing, by accentuating excursions of the diaphragms, rules out paradoxical movements. X-rays become permanent records for leisurely study and serial comparison.

The "match test" is done by holding a steadily-burning standard book match six inches from the patient's open mouth. Ask him to inhale deeply and then to exhale as rapidly as possible in an attempt to blow out the light. About 70 per cent of our patients with maximal voluntary ventilations *above* 50 *per cent* of their predicted values have been able to extinguish the match; while 70 per cent with values *under* 50 *per cent* of predicted value have been unable to do so.

Pulmonary function tests do not localize lung pathology or provide rapid anatomic or etiologic diagnoses. The normal range for any of these tests is wide and we still do not have

*This work is from the Seton Hall College of Medicine and the Thomas J. White Cardiopulmonary Institute, B. S. Pollak Hospital for Chest Diseases. Dr. Cohen is clinical assistant Professor of Medicine, Seton Hall College of Medicine, and Associate Director, Thomas J. White Cardiopulmonary Institute.

1. Comroe's book is published by the Year Book Publishers in Chicago. A 2d edition (1962) is now available.

2. Knowles' book was published by the Harvard University Press in 1959.

sufficient control data for normal persons of both sexes in all age groups. Lung pathology, if small in extent, must be strategically placed to compromise function at all. Testing does provide a quantitative estimate of disability and dysfunction and may unmask handicaps before characteristic physical and radiologic signs appear. Serial testing of the same person allows us to trace the natural history of the particular disorder under observation, and records the impact of medical and surgical treatment. Prediction of operative risk in chest and other surgery can be surprisingly accurate. The breathlessness of psychosomatic disorders can be differentiated from that due to organic disease. Finally, these studies have a place in industrial, pre-employment, compensation and insurance deliberations.

Ventilation studies are most appropriate for the generalist's office. Measurement of the vital capacity and its timed fractions is the irreducible test minimum. The vital capacity is the largest air volume that can be exhaled by voluntary effort following the deepest possible inhalation. Various figures express the per cent of the total vital capacity expired in the first 0.5, 1.0, 2.0 and 3.0 seconds. Many devices are now available for vital capacity estimates. The Buhl Spirometer [3] is a one pound, pocket-sized, apparatus with a dial registering up to 7,000 cubic centimeters; this spirometer and a supply of disposable mouthpieces fit into the physician's bag or may be placed in an examining tray or bedside stand. The McKesson "Vitalor"[4] is a somewhat larger (but lightweight and portable) device which inscribes the vital capacity curve on a graphic record which can be filed with the patient's chart (Figure 1). The same chart may be used on several visits to determine ventilatory changes. I have found the accuracy of the "Vitalor," the availability of a record for calculation of timed vital capacity percentages and the ease of testing all features which recommend it for routine office and bedside use. The Gaensler "Timed Vitalometer"[5] (Figure 2) is a still larger device incorporating an electronic timer permitting selection of various timed vital capacity fractions. A solenoid halts the movement of one pointer at this pre-determined interval while the second pointer advances to the total vital capacity. Although there is no visual record for filing or inspection, the Gaensler apparatus facilitates screening of large numbers of people in clinics, schools or factories in a very short time. The most versatile, but least portable, apparatus for the office is the compact 9-liter Warren Collins Respirometer [5] (Figure 3) with which



Figure 1. McKesson Vitalor



Figure 2. Gaensler Vitalometer

3. Imported Specialties and Supplies, Inc., Boonton, N. J.
4. McKesson Appliance Company, 228 Ashland Ave., Toledo 10, Ohio.
5. Warren E. Collins, Inc., 555 Huntington Ave., Boston 15, Mass.



Figure 3. Collins Respirometer.

one may record vital capacity and its timed components, expiratory and inspiratory curves, resting and maximal voluntary ventilations, lung volumes and oxygen uptakes.

Whether one uses the McKesson, Gaensler or Collins spirometers, values of 70, 80 and 90 per cent of the total actual vital capacity are considered normal for the first 1, 2 and 3 seconds (respectively) of this forced exhalation. Vital capacity time should not exceed 4 seconds for the normal individual. With obstruction to expiratory air-flow (as in asthmatic, bronchitic and emphysematous patients) the vital capacity may be normal but performance time is prolonged and the timed vital capacity percentages are reduced. If these figures improve following the use of a nebulized bronchodilator, the physician should suspect potentially reversible (bronchospastic) disease and can prescribe accordingly. In so-called restrictive disorders where lung tissue is replaced, obliterated, compressed or collapsed, or where the thorax "bellows" action is inadequate, vital capacity is reduced, but timed percentages are normal. When obstructive and restrictive components are present (pulmonary emphysema *and* fibrosis) both the vital capacity and its timed fractions are low.

The maximal voluntary ventilation (formerly maximum breathing capacity) is the greatest volume that can be breathed by voluntary effort during 60 seconds; this is best obtained with th 9-liter Collins apparatus.[5] Recent lung hemorrhage and incipient respiratory muscle paralysis in poliomyelitis are contraindications to doing this test. An established asthmatic paroxysm may become worse or be precipitated by the strenuous effort of the procedure. Fortunately, the one second timed vital capacity can be obtained with less patient discomfort and without these hazards, and correlates well with the maximal voluntary ventilations. For these reasons, it is preferable for office use. There is little to be gained by various formulae which convert timed vital capaci y fractions to rough approximations of the maximal voluntary ventilation.

Various formulas have been proposed to try to derive a simple single-figure value for the overall performance of the respiratory apparatus or the physiologic lung fitness of the particular patient. Here are some useful ventilation formulae.

The Air Velocity Index (Gaensler, E. A.: American Review of Tuberculosis, 62:17, 1950) is determined by taking the per cent predicted maximal voluntary ventilation divided by per cent predicted vital capacity.

The Breathing Reserve Ratio (Cournand, A. and Richards, D.: American Review of Tuberculosis, 44:26, 1941) is obtained by dividing the maximal voluntary ventilation-minute ventilation by the maximal voluntary ventilation and then multiplying by 100.

The Walking Ventilation (Warring, F. C.: American Review of Tuberculosis, 60:149, 1949) is calculated by figuring the ventilation in walking 180 feet on level ground in one minute and dividing this by maximal voluntary ventilation.

The "Breathing Reserve Ratio" (Cournand and Richards) attempts to predict the point at which breathlessness first appears; when the ratio exceeds 93 per cent, dyspnea is commonly absent, and when below 80 per cent, it is usually present. Warring's "walking" formula divides the ventilatory volume needed

for the subject to walk 180 feet in one minute by the patient's maximal voluntary ventilation; mild dyspnea occurs at ratios of 0.3 - 0.5, and severe dyspnea is invariable above 0.5. Unfortunately, none of these indices is as informative as study of their component parts or the information gained from a careful history and physical examination.

Performance of these few basic physiologic procedures in conjunction with conscientious clinical and radiologic survey is within the province of every doctor in his practice. Once confidence is acquired, a surprising amount of information will be available concerning the ventilation abnormalities present and the value of the various treatments we use.

228 West Jersey Street

BIBLIOGRAPHY

Handbook of Respiration. Analysis and Compilation by Altman, P. L., Gibson, J. F., Jr. and Wang, C. C.: Edited by Dittmer, D. S. and Grebe, R. M.: National Research Council. Saunders, Philadelphia, 1958.

Comroe, J. H., Jr., Forster, R. E., II., DuBois, A. B., Briscoe, W. A. and Carlsen, E: The Lung. Clinical Physiology and Pulmonary Function Tests. Second Edition. The Year Book Medical Publishers, Inc., Chicago, 1962.

Cherniack, R. M. and Cherniack, L.: Respiration in Health and Disease. Saunders, Philadelphia, 1961.

Gordon, B. L.: Clinical Cardiopulmonary Physiology. Second Edition. Grune & Stratton, New York 1960.

Knowles, J. H.: Respiratory Physiology and Its Clinical Application. Harvard University Press, Cambridge, 1959.

Williams, M. H., Jr.: Clinical Applications of Cardiopulmonary Physiology. Hoeber Harper & Brothers, New York, 1960.

Before the First Injection or Capsule

For every 100 drugs researched in this country 99 are discarded, but the research has to be paid for. Some would be potent and kill off the patient. We not only have to find something that can kill disease, we must make it safe. This costs money. When we buy a drug we're paying for the research in the past which made it possible; we're paying for the continuous research which will make even more and better things available. Take any of the great pharmaceutical companies of this nation and you can point out that many millions of dollars are spent before the first injection or the first capsule is given, after it has been made safe.—Edward R. Annis, M.D., in *Journal of Indiana State Medical Association*, July 1961.

Not True to Life

"The inference is not justified that our scientifically trained and able doctors are not capable of critically evaluating the publications of new drugs. Doctors have told me that the intimate doctor-patient relationship has been damaged by such inferences from Washington and by articles like the one in *Life*, which urged patients to press their doctors to prescribe cheaper drugs. Most of you saw the *Life* article '*A Big Pill to Swallow*' but did not see letters to the editor pointing out errors of fact in the original article. The drug on which the article was centered retailed at an average price of only 11.3 cents and not 30 cents as *Life* had written."—*The Drug Industry—Robbers or Heroes?* Alex Guerry, Jr., Brayton Pharmaceutical Company.

Letters to The Journal • • •

THE RESEARCH FOCUS IN MEDICAL SCHOOLS

Dear Sir:

In the July 1963 issue of this JOURNAL (60:255) I was taken to task editorially for my projection of Rutgers Medical School in which I pointed, among other things, to the role of research in the anticipated curriculum. Your editor expressed concern lest the growing emphasis upon research and the support of research in medical schools may in some fashion be operating to the disadvantage of the medical practitioner and of those schools whose main job is the creation of medical practitioners.

To several of the views expressed I must take exception. Clearly it is the job of Rutgers Medical School and of every other medical school to train medical practitioners. The anxiety that a research orientation precludes a school from producing practicing physicians has no substantial foundation. That medical school in this country which exceeds all others in its research efforts and expenditures "converts" only about 15 per cent of its alumni into academic aspects of medicine, teaching and research. Well over 80 per cent enter medical practice. Despite the great support given to research in medical schools, approximately 95 per cent of all alumni make careers of medical practice and I would anticipate no striking deviation from this average for Rutgers alumni.

There are of course many reasons why every modern medical school places increasing stress upon the research aspects of medical science and medical education. At a practical level, in a very competitive market for faculty, each school must endeavor to supply those perquisites most highly prized by the best teachers and finest minds in medicine. In my opinion, the opportunity to conduct research and to associate with those who do, stands, for the best faculty, at the top of this list of attractions. Any school which neglects this will assemble a mediocre faculty and is doomed to mediocrity, not only as a research center but also as a teaching institution.

But there is a more profound reason for an increasing interest in research at medical schools and this relates to the changing character of medicine itself. With the decline of empiricism, with increasing dependence and reliance upon the findings of the laboratory scientist, medicine is itself becoming a scientific discipline. If large sectors of medicine are even today to be considered in the realm of science, and if, as must be supposed, medical science continues to develop at an accelerating rate, then clearly medicine must be taught and learned as a science. To teach science, whether it be biology, chemistry, or medicine, with no regard for the methods and results of research is today unthinkable.

We at Rutgers Medical School have taken as our ambitious assignment the training of physicians, not for 1960 but for 1970 and 1980. It is already quite clear that, to an ever increasing degree, the physician of the future will be called upon to understand and to evaluate the results of the research of others. Only by so doing will he be able to choose among the host of new drugs, new procedures, as they are described and published. Furthermore, with growing knowledge and a greater array of methods and equipment at his disposal, is not the practitioner of medicine compelled to become something of a researcher in his daily practice? Even today each successive diagnostic and therapeutic problem presented to the physician is a research problem in microcosm. Medicine assumes, and quite properly, the attitudes of science and willy-nilly the work of the medical practitioner comes to resemble the work of the chemist or physicist. His work we call research.

It is because we believe that it is the best, perhaps the only way, to produce forward-looking physicians for the decades ahead that, in harmony with other vigorous schools, we at Rutgers are developing research aspects of the curriculum. This does not mean that other didactic parts of the traditional medical curriculum, if of proven value, will be discarded. We shall seek that combination of clinic and laboratory, of teaching, research and service, which provides the most favorable environment for the flowering and dissemination of medical knowledge.

Your editor appears to deplore the very great increase in the support of research in medical schools. I must also deplore those occasional instances in which a man or an institution is corrupted and changes objective

merely because large sums of money are readily available. I am convinced, however, that this is the exception rather than the rule. The increase in support of research at medical schools, although it has certainly created some problems, has clearly been of enormous benefit not only to science but indirectly to education. Over the past half century, the best in American medical research has been conducted at medical schools by faculty members and students and the advance of medical science largely reflects this fact. The increase in dollar support is a recognition by the people and the law-makers that they like what they have gotten and want more of the same.

DeWitt Stetten, Jr., M.D., Ph.D.
Dean, Rutgers Medical School

Psychosomatic Profile • • •

Psychosomatic Geriatrics

Psychosomatic illnesses are not more common in the aged; but the stresses and strains which cause them are different from those in the teenagers ad younger adults.

Remember that a history should include an account of any mental or emotional stress or strain which may have preceded the physical complaints. Once it has been decided that no organic disease is present, and after an explanation is made to the patient, it is important *not to repeat laboratory or x-ray examinations* on continued complaints by the patient.

I recall a 74-year old woman who was a patient of mine for several years with minor physical complaints. She has compensated arteriosclerotic heart disease with a mild hypertension. A year ago, it was my unhappy experience to have to break the news to her that her forty-year old son died rather suddenly. I was amazed at her reaction to the news. She was, of course, surprised, but she rationalized her son's death as being "God's will." Shortly thereafter, she started to complain of headaches and visual difficulties. X-rays of the skull were essentially negative. At the request of her ophthalmologist, because of a field defect, arteriography was done. This, too, was negative.

The patient no longer complains of her head or eyes. Now she has periods of crying with depression. She is having a "grief reaction" now of about one year's duration. Brief supportive psychotherapy is given her at irregular intervals as well as a mild sedative. Her roommate reports that she is difficult to live with, but she was not referred for formal psychiatric therapy because she is slowly making an adjustment.

Another case is that of a 68-year old woman complaining of vague digestive disorders including belching, constipation, and flatulence. There has been no weight loss and she is not anemic. She tires easily and gets short of breath. She rarely has a good day. All examinations were within normal limits. Although she has been going to doctors for many years, there has been an intensification of her complaints since the death of her husband a year ago.

After several visits, it became obvious that the patient was depressed. She improved with mild mood-elevating drugs. She complains less, but she still needs help for her digestion. This patient has psychosomatic complaints secondary to a depressed state. I would refer her for psychiatric treatment, and possibly electrotherapy, if she were losing weight, or were becoming slovenly or suicidal.

—Matthew Molitch, *M.D.*

Trustees' Minutes: July 21, 1963

A regular meeting of the Board of Trustees was held at the Executive Offices on July 21. Detailed minutes have been sent to each component society for information of the membership. A summary of the significant actions of the Board follows:

New Jersey Welfare Council . . . Accepted the invitation to co-sponsor the section meeting on "Narcotic Addiction and Control" during the annual conference of the Welfare Council to be held in Asbury Park October 29 to 31.

Consultative Service for Convulsive Disorders . . . Approved the President's appointment of Dr. J. Lloyd Morrow of Passaic to the steering committee for the new program being organized by the New Jersey Consultation Service for physicians treating neurologic cases in need of further consultation.

Office Manager . . . Approved the engagement of Mr. Robert H. Lambert as office manager.

Greisman vs. Newcomb Hospital . . . Accepted the report of legal counsel as follows:

"The Supreme Court has taken the position that the hospital's power to pass on staff membership application is a fiduciary power, and (1) any applicant is entitled to have his application evaluated on its own merits, without regard to a bylaw requiring county medical society membership, or (2) an M.D. degree from an approved medical school. Therefore, our highest court has ruled that a refusal to consider an application *solely* because of osteopathic schooling is arbitrary, unrelated to sound hospital standards, and not in furtherance of the common good."

AMA Institute . . . Authorized the President, Chairman of the Council on Public Relations (Dr. John Kustrup of Trenton) and the Executive Director to attend the AMA Institute in Chicago on August 22 and 23.

AMA Conference on Maternal and Child Care . . . Authorized the Society's Chairman of the Committee on Maternal and Infant Welfare (Dr. John Preece of Trenton) to attend the conference to be held October 14 and 15 at the Greenbrier in West Virginia.

SMJAB Conference . . . Authorized the Assistant Editor (Theresa E. Goeke) to attend the Journal Conference in Chicago on October 21 and 22.

Current Legislation . . . Noted that the following bills have been enacted into law:

S-57 —To provide that certain notices of hospital and medical liens may be filed in the county clerk's office within 90 days after the first day of treatment.—Chapter 99, P.L. 1963

S-77 —To prohibit the practicing of optometry in retail stores, or offices not exclusively devoted to that practice.—Chapter 77, P.L. 1963

S-181 —To require the licensing of blood banks and to regulate their operation.—Chapter 33, P.L. 1963

A-193—To provide that data in possession of the State Department of Health, pertaining to the health of any named person, procured in connection with research studies approved by the Public Health Council for the purpose of reducing the morbidity or mortality from any cause or condition of health shall be kept in confidence by the Department except to persons participating in research study or in such impersonal form that the individual concerned cannot be identified.—Chapter 68, P.L. 1963

A-243—To extend from 2 to 5 years the period during which a resident may serve as such without being required to obtain a license to practice medicine; and permits staff members of state and county institutions, at the discretion of the Board of Medical Examiners, to serve indefinitely without being licensed.—Chapter 30, P.L. 1963

Hospital Utilization Under Blue Cross . . . Approved the report of the Medical-Hospital Liaison Committee, as follows:

The representatives of the Hospital Association made it abundantly clear that they are as little satisfied as are the representatives of MSNJ with the action taken by Blue Cross in connection with re-certification by the attending physician every 14 days of the patient's need for further in-hospital treatment. As early as April 26, 1963, NJHA had suggested to Blue Cross that MSNJ be included in discussions concerning the technique for controlling hospital utilization, especially in connection with the plan recently announced by Blue Cross. The Board of Trustees of NJHA adopted a resolution on July 16, 1963, calling upon Blue Cross to with-

draw its present program pertaining to the 14-day recertification system.

Inasmuch as there is and should be a close operating bond between Blue Shield and Blue Cross, it was the opinion of the joint liaison committee that in any discussion involving physicians in conjunction with the operations of Blue Cross, representatives of Blue Shield should be included in conference. Therefore, the committee agreed to *recommend* to their respective organizations:

> That in future all matters of this kind be discussed in a four-party conference attended by representatives of Blue Shield, Blue Cross, NJHA, and MSNJ.

Medical Assistance for the Aged Program . . . Appointed Dr. Frank Hughes, of Camden—a member of the State Board of Control—as the Society's official representative on an advisory committee of physicians set up by the Bureau of Medicine in the Division of Welfare.

Physician-Hospital Relationships . . . Received the report of the Medical-Hospital Liaison Committee that New Jersey Hospital Association representatives have manifested "an interested and cooperative attitude toward the 'Guides,' and at the suggestion of Dr. Kaufman agreed to organize a committee to study the proposed guides and to commit their constructive suggestions in writing for subsequent discussion with the subcommittee of the Council on Medical Services entrusted with the responsibility of evolving the proposals in final form."

Medicare Program . . . Authorized the proper officials of MSNJ to execute the agreement of indemnity, as follows:

> To validate the Medicare contract renewal for 1963-64, an agreement of indemnity on behalf of MSA in the sum of $20,000 is required to support advances up to $100,000 for the program revolving fund. The necessary papers have been executed by MSA officials.

Medicare Fiscal Agent . . . Designated Medical-Surgical Plan of New Jersey as the fiscal agent of MSNJ for the Medicare Program beginning with the next contract year, July 1, 1964—June 30, 1965.

MSP Board . . . Received the following nominations from MSP, approved by the Plan Board at its June meeting:

> Robert E. Verdon, M.D., General Practitioner, Bergen County, 3 year term; and
>
> Sidney I. Simon, Ph.D., Professor of Economics, Rutgers University, 3 year term, to fill the unexpired term of F. Clyde Bowers, M.D., resigned.

Professional Liability Rate Increase . . . Approved the recommendations of the Medical Defense and Insurance Committee, as follows:

> The committee reviewed and discussed at length the official announcement to MSNJ from American Mutual Liability Insurance Company concerning the rate increase, effective July 1, 1963. The State Department of Banking and Insurance approved the new rates for the National Bureau of Casualty Underwriters for medical professional liability insurance, effective June 26, 1963.
>
> The following *recommendations* were adopted:
>
> (1) that the Board of Trustees be notified of the rate increase; and
> (2) (a) that, in the interpretation of the classifications submitted by American Mutual, a mandatory classification shall be attached to those individuals who have certification in the specialties of Class I; and
> (b) That non-board certified physicians shall be guided in their designation of their classifications by the medical-surgical privileges accorded them under their hospital affiliations.

AMA Delegates . . . Commended the AMA delegates and officers for their diligent work at the most recent AMA meeting in Atlantic City.

Medical Student Loan Fund . . . Approved the action of the committee, as follows:

> In the event the borrower enters military service with the Armed Forces of the United States following internship or following internship and residency, his or her repayment of the obligation shall commence as though practice of medicine had begun on the date of entrance into such military service.

Welfare Prescriptions . . . Requested Dr. Louis Wegryn to meet with the Medical Director of the Division of Welfare concerning the revision of welfare prescriptions and M.D. vendor voucher forms.

Academy Library Initiates Photoduplication Service

The Library of the Academy of Medicine of New Jersey now offers Xerox copies of items in its collections. Photoduplication request forms and additional information about this service may be obtained by calling the Library at PI. 8-3430 or PI. 8-3431; or by writing to the Library at 315 Belleville Avenue, Bloomfield, N. J.

Announcements • • •

Do You Have a Paper for the AMA?

Would you like to present scientific papers before the AMA in 1964? If so, communicate with the Secretary of the appropriate Section before December 10, 1963. The Secretaries and their addresses are listed in THE JOURNAL AMA in the last issue of every month.

If you want space in the Scientific Exhibit, get application forms from the Department of Scientific Assembly, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois. Deadline is December 31, 1963.

Those who desire to present motion pictures will request forms from the Medical Motion Pictures Department of the Scientific Assembly of the American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois. Deadline is December 31, 1963.

Economics of National Security

An unusual and intensive correspondence course in the "economics of national security" is now available to Army and Navy reserve medical officers and to selected civilian physicians. The course deals with all segments of our country's economy including the appraisal and utilization of human and natural resources, foreign relations, our service and production potential and the way all these gear into problems in national security. To determine if you are eligible for this unique, high level educational program, write to Industrial College of the Armed Forces, Fort Lesley McNair, Washington 25, D. C.

Asthma Symposium

You are welcome to attend a seminar on asthma to be held at the Children's Heart Hospital, 3701 North Broad Street in Philadelphia. This symposium will be held on November 5 and 6 and will focus on principles and practice of bronchopulmonary therapy with special emphasis on the rehabilitation of the intractable asthmatic. A star-studded faculty has been provided, and the AAGP will give credit for attendance. For more details, write to Dr. Leonard S. Girsh, 1025 Beury Building, 3701 North Broad Street, Philadelphia 40, Penna.

On to Portland

More than 7,000 physicians and their guests will converge on Portland, Oregon, for the Clinical Meeting of the American Medical Association, December 1, 2, 3, and 4. This is the first time that AMA has held a clinical session in Portland. The association has held two of its annual meetings in Portland, however: 1905 and 1929.

Nearly all of the scientific sessions will be held in Portland's new Memorial Coliseum. The scientific and industrial exhibits also will be shown there. Conveniently located, this magnificent Coliseum offers new facilities throughout.

When the AMA held its clinical meeting in Seattle in 1956 the total physician attendance was 3,032. It is anticipated that this figure will be much higher when the AMA meets in Portland.

Lectures, panels, symposia and breakfast roundtables again will be presented at the Portland meeting on specially selected topics, as well as color television and medical motion pictures. More than 100 physicians will deliver lectures on the scientific program during the four-day meeting, and more than 200 scientific and industrial exhibits will be shown at the Coliseum. Many of these are based on new scientific research. These exhibits are so varied that the medical subject matter has some interest to every physician regardless of specialty.

Teaching Resuscitation

You can develop demonstrations and other teaching aids at your hospital for instruction in cardiac massage and mouth-to-mouth resuscitation. Three modalities of instruction are now available to hospitals in this state:

1. A 16-millimeter sound-color film, called "The Pulse of Life."
2. Slides on resuscitation prepared by Johns Hopkins faculty members.
3. Demonstration and lecture by trained physicians.

If interested, submit request to: Heart and Circulatory Program, State Health Department, Box 1540, Trenton 25.

Obituaries • • •

DR. FRITZ W. PLINKE

One of Passaic County's leading surgeons, Dr. Fritz Wilhelm Plinke, died at the Passaic General Hospital on July 8, 1963, at the age of 73. Born in Germany, he received his medical degree at Goettingen in 1914. In 1924 he came to the United States and set up an office in Passaic. He joined the staff of the Passaic General Hospital and in 1951 and 1952 served as president of that staff. He was also active in the affairs of the Passaic County Medical Society.

DR. CHARLES FRANCIS POST

An active and promising career in dermatology was prematurely cut short on July 10, 1963 with the death that day of Charles F. Post, M.D., Assistant Professor of Dermatology at Columbia University. Born in New York in 1921, he received his M.D. at Rochester in 1944. He was then commissioned in the Navy and saw service in the Pacific. On being demobilized, Dr. Post took a residency in dermatology at the Roosevelt Hospital in New York City. He became a Board diplomate in his specialty and entered private practice in Ridgewood, New Jersey. He was affiliated with most of the hospitals in the Bergen County area and was associate dermatologist at New York's Presbyterian Hospital.

DR. ABRAHAM A. RUBIN

Born in Philadelphia in 1901, Dr. Abraham Alba Rubin died in East Orange on July 20, 1963. Dr. Rubin received his M.D. at Hahnemann in 1925. He interned at the Delaware General Hospital in Wilmington and then came to the New York area for a surgical residency at the Metropolitan Hospital. He then moved to Belleville, and practiced surgery there for some years before moving to East Orange where he maintained his office therefore. He became an attending surgeon at East Orange General Hospital and was chief of surgery at the American Legion Memorial Hospital. During World War II he was a major in the medical corps and had a surgical assignment in North Africa.

DR. JOHN J. SZYMANSKI

One of Passaic County's senior practitioners, Dr. John J. Szymanski, died at his home on July 3, 1963 at the age of 76. Born in Brooklyn, his family took him to Passaic, New Jersey when he was a child. In 1914 he received his M.D. degree at Johns Hopkins. When war broke out in Europe the following year, he volunteered for service with the Red Cross and was sent to the Balkans as a medical inspector. When the United States entered the war in 1918, he transferred to our medical corps. After he was demobilized in 1920 he returned to the Red Cross doing public health and medical inspecting for them in Russia. A few years later, he was offered and accepted a Rockefeller Foundation grant in public health, and Johns Hopkins awarded him a D.P.H. degree for subsequent graduate study in that field.

Dr. Szymanski then returned to Passaic where he entered general practice. He was also a pioneer in radiology and roentgenology, and was an early diplomate of the American Board of Radiology. He was affiliated with Passaic General Hospital. Always active in communal affairs, he had a tour of duty on the Passaic Board of Education.

DR. WALTER A. WADSWORTH

On the 4th of July, acute leukemia took the life of Dr. Walter Wadsworth at the early age of 43. Dr. Wadsworth received his M.D. at Wake Forest in 1951. He interned at the Queens (N.Y.) General Hospital and then moved to New Brunswick where he set up an office for general practice in 1953. He was on the staff of both hospitals in New Brunswick and also worked at the Middlesex Rehabiltation Center. An amateur pilot of considerable skill, Dr. Wadsworth was a member of the Brunswick Flying Club. During World War II—which was prior to his admission to medical school—he was a captain in our Air Corps, flying missions to and over Burma.

DR. THOMAS J. WALSH

Union County lost one of its most distinguished members on August 25 with the death that day of Dr. Thomas J. Walsh. Born in New York in 1898, he received his degreee at Long Island College Hospital in 1920. He then accepted an internship at St. Elizabeth's Hospital in Elizabeth, and remained for the rest of his professional life in that part of New Jersey. He was active in civic, church, and medical society affairs. He had been president of the Union County Medical Society. He had been chief of staff at Alexian Brothers Hospital and president of the staff at St. Elizabeth's. He had served as director of surgery at both institutions. He was a Fellow of the American College of Surgeons. In 1954, Pope Pius XII named him a Knight of St. Gregory. In 1963, Pope John XXIII elevated Dr. Walsh to the rank of Knight Commander of St. Gregory. This is the highest papal honor ever given to laymen.

Book Reviews

Malpractice Law Dissected for Quick Grasping. By C. L. Cusumano. New York, 1962, Medicine-Law Press, Inc., 42 Broadway. Pp. 132. ($10.00)

In spite of its pretentious title, this is a vivid and usable analysis of malpractice. Mr. Cusumano leads us hand-in-hand through what looks, at first, like a dreadful jungle. He outlines the elements of malpractice, spells out what the lawyer must do to prove his case, lists possible defenses, enumerates the commoner grounds, highlights the mechanics of the trial itself, and reviews liability insurance. He does not forget the malpractice problems of nurses, dentists, hospitals and employees of physicians. In a much too-short chapter (only two pages) he lists some tips on avoiding malpractice claims.

Mr. Cusumano put more emphasis on the "contract" aspect of the physician-patient relationship than do most legal authorities. He points out that some doctors issue panic-provoking statements—like certain remarks about surgery by GP's which only stir up litigation. He reminds us that young and inexperienced physicians get fewer claims against them. He reviews some of the interesting semantic implications of the very word "malpractice" which we physicians shun in favor of "professional liability." The author presents an interesting table in which precipitants of litigation are divided into factors based on treatment and factors based on diagnostic methods.

We are advised to make much wider use of written communication with patients. The author recommends printed or written agreements on treatment technics and on limitations of care. He urges that a patient who does not want to know the truth be required to sign a statement to that effect; and that if he has been informed of the risks of treatment, the patient should put that in writing, too. Legally, this is sound advice, but one wonders how practical it is in a doctor's daily work.

Mr. Cusumano thinks that "juries are likely to be most considerate of defending doctors"; that "the law favors doctors"; that "physicians are not discriminated against"—all of which would be good if true.

Mr. Cusumano gives adequate space to certain items often ignored or played down in the more standard treatises. These include: effect of premature release of a patient; special liabilities of dentists; medico-legal aspects of experimentation—a potential malpractice booby trap these days in view of the many new drugs being offered; duty to call in a consultant; special problems related to blood transfusion, shock therapy, care by nurses, cardiac arrest during surgery and liability of employers of physicians as well as employees of physicians.

The reader will be interested in the chapter on how a case is proved in court. Vividly written, it displays the problem in step-by-step fashion, and covers both the usual, and certain heterodox methods of proof. The author includes a compact treatise on *res ipsa loquitur*, a doctrine which most doctors find repugnant, but which Mr. Cusumano explains without passion. The chapter on "the physicians' defenses" is of some comfort and may be of practical value.

The book is written in easily-understood language. It holds the reader's interest, and has the flavor of a fast-moving conversation with a knowledgeable lawyer.

HENRY A. DAVIDSON, M.D.

Renal Biopsy (Clinical and Pathological Significance). By G. E. W. Wolstenholme and Margaret P. Cameron. Boston, 1961. Little, Brown and Company. Pp. 395. Illustrated. ($10.50)

This book records international symposium on renal biopsy held in London in 1961. It is the first text devoted exclusively to this relatively new diagnostic procedure and testifies to the large amount of data accumulated in the 10 years since the first series was reported.

Thirteen papers are presented followed by a discussion of each. Subjects include the morphologic and clinical associations in the nephrotic syndrome, glomerulonephritis, lupus nephritis, pyelonephritis and acute anuria. There are several excellent papers on electron miscroscopy in the normal and abnormal kidney as well as a paper on histochemistry of biopsy material. The editors have provided a selective bibliography and excellent discussions at the end of each paper which help the reader to fill in his gaps and adjust his perspective.

It is unfortunate that there are no papers on diabetic glomerulosclerosis and toxemia of pregnancy since renal biopsy has made significant contributions to our knowledge of the natural history of these conditions.

The final discussion and summary presents the views of those who would biopsy the renal patient in contrast to those who would biopsy only for a possible therapeutic decision. It includes a presentation of the complications of the procedure and the importance of having an experienced team to perform the biopsy as well as to prepare and read the biopsy material.

Some will find the subject matter difficult. They should, however, finish the book with an increased respect for the amount of information which can be gained by renal biopsy, a knowledge of the inherent errors in the procedure, and an added awareness of its indications.

NORMAL LASKER, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

OCTOBER, 1963 • VOL. XXXVI, No. 8

NATIONWIDE HISTOPLASMIN SENSITIVITY

State-to-state variations in histoplasmin sensitivity are shown by skin test results in a large group of Navy recruits. An attempt was made to estimate the frequency of histoplasmal infection and of other cross-sensitizing infections in recruits from each state.

Results of skin testing with histoplasmin and the diagnosis of clinical cases of histoplasmosis have made it clear that where people live is of prime significance in the risk of becoming infected with the fungus *Histoplasma capsulatum.*

In the study here reported, an attempt was made to depict state-to-state variations in indigenous sources of sensitivity to histoplasmin as measured by reactions among young men who had lived all their lives in one state.

With the cooperation of the U. S. Navy, 306,226 United States Navy recruits on entering training centers at Great Lakes, Ill., and San Diego, Calif., were given several skin tests, including histoplasmin. Among white recruits between 17 and 21 years of age, 212,462 had lived all their lives before entering the Navy in only one state in the conterminous United States.

In terms of reactions to histoplasmin, the highest prevalence rates among lifetime residents of one state were in the east-central parts of the country—Missouri, Indiana, Kentucky, Tennessee, and Arkansas—where more than 55 per cent reacted. (Illinois would have been included except for the low prevalence from the Chicago area.) In many of the adjoining states the rates ranged from 29 to 45 per cent, in others from 11 to 25 per cent. Toward the southeast the frequency of reactors dropped more rapidly, to less than 11 per cent in Georgia and less than 4 per cent in North Carolina. The rates were also below 4 per cent in the northwestern and New England states, and higher in the Mexican border states.

CROSS-REACTIONS

A reaction to histoplasmin does not necessarily represent sensitivity caused by infection with *H. capsulatum;* cross-reactions are known to occur as a result of other systemic mycotic infections. Unless account is taken of possible cross-reactions, the prevalence of histoplasmal infection, as determined by the percentage of "reactors," may be grossly overestimated for some areas.

A theoretical distribution of "negative" reactions was based on combined results for recruits from five states in the northwest (Washington, Oregon, Idaho, Montana, and Wyoming) and five in New England (Maine, New Hampshire, Massachusetts, Connecticut, and Rhode Island) where the frequencies of significant reactions to histoplasmin were the lowest in the country. After subtracting the "negative" reactions from the distributions for other states, the sizes of the remaining or "positive" reactions were shown to be distributed differently in different parts of the country. For example, in Arizona and New Mexico, there were fewer large reactions but

PHYLLIS Q. EDWARDS, M.D., and CARROLL E. PALMER, M.D., *Public Health Reports,* March, 1963.

more small ones than in West Virginia and Maryland. Infection with *Coccidioides immitis* is known to be prevalent in the southwest, and a substantial proportion of the reactions to histoplasmin in this region unquestionably are small because they are cross-reactions. But, as far as is known, *Coccidioides* does not exist in Louisiana, Nebraska, and the southeast, yet in these regions, too, there was a disproportionate increase in the frequency of small reactions. These should also probably be considered cross-reactions, though not attributable to coccidioidal infection.

RESIDENCE HISTORIES CHECKED

The very low frequency of large reactions to histoplasmin in the northwestern states raises some questions as to their source. Because of the high frequency of migration to the northwest from the east-central states (where histoplasmin sensitivity is high), even a few errors of omission in the residence histories of the recruits would have a significant effect. Indigenous sources of infection, though a possibility, seem fairly unlikely since the few reactors were widely scattered throughout the region rather than concentrated in single counties or localities. Letters were written to recruits from the northwestern states who had a reaction of at least 5 mm., asking for a detailed list of all places they had ever lived or visited.

Replies were received from 71, or 59 per cent, of the 121 questioned. A history of having been in areas where they might have acquired histoplasmin sensitivity was obtained from 26; of these, 19 had reactions of 8 mm. or more. In contrast, among the 45 who had never been outside the northwest, 14 had reactions of 8 mm. or more. Thus, the larger the reaction, the greater the likelihood that the recruit had been in an area where histoplasmin sensitivity was more prevalent than in his home state. However, if the few scattered reactions found among recruits who had never left the state are in fact evidence of indigenous sources of infection with *Histoplasma* in the northwest, then such sources would seem to be located in areas where people rarely go.

OPPOSITE SITUATION IN NEW ENGLAND

Similar letters were sent to a corresponding sample of recruits from the New England states where the frequency of reactions was low. Of 34 who replied, only 8 had ever lived or visited in states outside New England, and 6 of the 8 had reactions of 8 mm. or more. However, of the total of 18 with reactions of 8 mm. or more, 12 had never left the area.

Thus, in contrast to the northwest, it seems likely that sources of infection are present in one or more of these states.

From the analysis in the present report, based on the use of a repetitive analog computer to estimate the frequencies of specific reactions and cross reactions, it becomes possible to account for some of the otherwise incomprehensible variations in the distributions of reactions to histoplasmin among population groups in different geographic areas. *Coccidioides* infection as the predominant cause of cross-reactions in the southwest is readily acceptable. The task is to be on the alert, particularly in the Gulf and southeastern states, for signs of other fungi that may be infecting and sensitizing a good many people and, perhaps, causing clinically recognizable disease in only a few of them.

It also appears that the epidemiology of histoplasmosis, as well as other fungus infections, may well be strongly affected by the density and movement of populations in regions where the organism exists naturally.

NEW JERSEY TUBERCULOSIS AND HEALTH ASSOCIATION
15 EAST KINNEY STREET, NEWARK 2, NEW JERSEY



The Lady Governors of the Old Men's Home at Haarlem FRANS HALS, 1580/81-1666

In Geriatrics...

METAMUCIL® Provides Bland Smoothage

brand of psyllium hydrophilic mucilloid

The tendency of the elderly to subsist on low-residue foods often is a prime cause of bowel sluggishness. Adequate fecal content is necessary to maintain normal colonic function, since intracolonic distention is nature's method of stimulating reflex peristalsis.

Metamucil, therefore, fulfills a basic function in the treatment of geriatric constipation. It both softens hard, dehydrated fecal concretions and adds smooth, nonirritant, easily compressible hydrophilic bulk.

Metamucil applies a physiologic principle to correct constipation naturally.

Average Adult Dose: One rounded teaspoonful of Metamucil powder (or one packet of Instant Mix Metamucil) in a glass of cool liquid. To Metamucil powder, a refined, purified and concentrated psyllium hydrophilic mucilloid, an equal amount of dextrose is added as a dispersing agent. Each dose of the powder furnishes a negligible amount of sodium and 14 calories. To the mucilloid in Instant Mix Metamucil citric acid, sodium bicarbonate and mild flavoring are added. Each dose of Instant Mix Metamucil furnishes 0.25 Gm. of sodium and 3 calories. Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons of 16 and 30 single-dose packets.

G. D. SEARLE & CO.
CHICAGO, ILLINOIS, 60680
Research in the Service of Medicine

FAIR OAKS HOSPITAL

SUMMIT, NEW JERSEY

CRestview 7-0143

OSCAR ROZETT, M.D.
Medical Director

MOLLIE KENNEDY, R.N.
Director, Nursing Service

EDWARD R. DUTY, M.D.
Clinical Director

N. M. JANI, M.D.
S. D. ESTRADA, M.D.
Associate Psychiatrists

THOMAS P. PROUT, JR.,
Administrator

AN 85 BED INTENSIVE TREATMENT PSYCHIATRIC UNIT

Certified by
The Joint Commission on Accreditation of Hospitals
The Central Inspection Board, American Psychiatric Assn.







Estate Security Corporation • Legatees Funding Corporation

L. JOSHUA WEINER, President

Estate, Corporate Analysts — Investment Advisors

Professional and Business Management Consultants

1180 Raymond Boulevard
Area Code 201

Newark 2, New Jersey
MArket 2-6620-21

Office Suites Available - New Medical Building
Kinnelon, New Jersey

Area in need of general practitioner, surgeon, obstetrician, pediatrician, dentist.

HENRY D. RICKER, Broker — **BUTLER, NEW JERSEY — TE 8-0400**

Raymond A. Lanterman & Son

Exclusive Funeral Service

126 SOUTH STREET — MORRISTOWN, N. J.

PHONE JE 9-2880

R. A. Lanterman — Wm. V. D. Lanterman

Announcing a valuable new aid for all who treat young patients

A New Book!
CURRENT PEDIATRIC THERAPY
Edited by
Gellis and Kagan

This entirely new book. *Current Pediatric Therapy*, will enable you to enjoy the same type of specific *therapeutic* recommendations for your young patients that readers of *Current Therapy* have been receiving for some fifteen years. Dr. Sydney S. Gellis and Dr. Benjamin M. Kagan have edited this new work, with contributions by over 200 leading authorities. Therapeutic details are pinpointed for more than 300 diseases—from *Kwashiorkor* and *Protein Deficiency* to *Infantile Cortical Hyperostosis*, and *Prematurity*. All the diseases and disorders in this book are treated in terms of how they afflict infants and children. Since this book equals Current Therapy in size, you can see how valuable this comprehensive text can be in this area of your practice.

All discussions are approached from the pediatric point of view, with dosages, diets, prescriptions, etc., written for infants and children. This new *Current Pediatric Therapy* concentrates on giving you the best treatments available today as they are currently being used by specialists with wide experience in specific areas. You will not find involved discussions of diagnosis and etiology here—just concise, clearly delineated details on the best treatments for virtually all the diseases and disorders you will be called upon to manage in your child patients.

Whether you need a diet for a phenylketonuric child, help on deciding the proper dosage of antiepileptic medication, or late information on immunization schedules, you'll find it spelled out precisely in *Current Pediatric Therapy*.

By 224 Leading Authorities. Edited by SYDNEY S. GELLIS, M.D., Professor of Pediatrics, Boston University School of Medicine; Director of Pediatrics, Boston City Hospital; and BENJAMIN M. KAGAN, M.D., Director of Pediatrics, Cedars of Lebanon Hospital, Los Angeles. About 864 pages, 7-7/8" x 10-7/16". About $16.00. New—Ready January!

Up-to-date help for your research and for your evaluation of other's work

New (2nd) Edition!
Mainland's ELEMENTARY MEDICAL STATISTICS

Here is an enlarged and improved *New (2nd) Edition* of one of the most respected American texts on medical statistics. Dr. Mainland has devoted the first ten chapters to expanded discussions on statistical *thinking*, rather than arithmetic. These beginning chapters are in the form of questions which you can ask yourself regarding your own research, and which you can apply to evaluation of the work of others. Each question is the basis for an explanatory discussion. In this section you'll find vital information on: *the nature of the research; purpose and general method of investigation; the population and sampling; interpretation; sample sizes; collecting and examining data.* Next, specific methods of analysis are presented and discussed. Chief attention is paid to methods a small scale investigator would use. In this latter portion of the book you'll find such topics as: *random processes; standard deviation; frequency distribution of measurements; causes of bell-shaped distribution; estimation of population percentiles; correlation coefficients, etc.*

By DONALD MAINLAND, M.B., Ch.B., D.Sc., Professor and Chairman, Department of Medical Statistics, New York University College of Medicine. 381 pages, 6⅛" x 9¼", illustrated. About $9.00.
New (2nd) Edition—Just Ready!

To Order Mail Coupon Below!

W. B. SAUNDERS COMPANY
West Washington Square, Philadelphia 5, Pa.

Please send when ready and bill me:

☐ *Current Pediatric Therapy*.....About $16.00

☐ Mainland's *Elementary Medical Statistics*.....About $9.00

Name.....

Address.....

SJG 10-63

"Prescribe with Confidence"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR
FOR MEN - WOMEN - CHILDREN



SOLD ON Rx ONLY
OUTFLAIR SHOES
FOR CLUB FEET

177A JEFFERSON AVE.
PASSAIC, N. J.

69 WESTWOOD AVE.
WESTWOOD, N. J.

350 MAIN ST.
HACKENSACK, N. J.

Dennis Brown Splints — in all sizes — carried in stock

The Morristown Rehabilitation Center

66 MORRIS STREET **MORRISTOWN, NEW JERSEY**
JEFFERSON 9-3000



NATHAN KAPLAN, M.D., Physiatrist
MARY E. JOHNSON, Chief Therapist

ANN G. McMANUS, R.N.
Director of Nursing Service

AUDREY E. TAHLMORE
Administrator

A 38-bed rehabilitation unit specializing in orthopedic and neurological disabilities. Speech therapy, Occupational therapy and psychological evaluation available.

- - - - - -

AMERICAN HOSPITAL ASSOCIATION ACCREDITATION
MEMBER NEW JERSEY LICENSED NURSING HOME ASSOCIATION

1919 *Milestones in Nutrition*

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

when vitamin D was missing...

. . . they turned to milk. In 1919 Mellanby found that rickets could be prevented by feeding small amounts of butterfat or cod liver oil. The active ingredient was later identified as vitamin D.

In contrast to earlier times, rickets is now rarely seen in the United States. The use of milk fortified with vitamin D has virtually assured an adequate intake of all the major factors required for proper nutrition of the bones . . . calcium, phosphorus and vitamin D. Milk is the only food which is approved for vitamin D fortification.

Besides its role in calcium absorption, vitamin D appears to be needed for the formation of bone salts and the regulation of phosphorus excretion. The most critical periods of life with respect to vitamin D nutrition occur during growth, pregnancy and lactation.

As they have in the past, milk and other dairy foods will continue to play a vital role in the nutritional welfare of our people.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.



Since 1915 . . . promoting better health through nutrition research and education

NATIONAL DAIRY COUNCIL

a non-profit organization

202 EAST 44TH STREET • NEW YORK 17, NEW YORK

AVAILABLE ON REQUEST: Reprints of this series of messages on "MILESTONES IN NUTRITION" and "CALCIUM IN NUTRITION" booklet



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE MARK (R)

GREENLEAF FUNERAL HOME

108 West Palisade Avenue

ENGLEWOOD, N. J.

LO 8-0416 Est. 1893

ANNUAL CLINICAL CONFERENCE

Chicago Medical Society

MARCH 2, 3, 4 and 5, 1964

PALMER HOUSE, CHICAGO

Lectures
Medical Color Telecasts
Teaching Demonstrations
Film Lectures
Instructional Courses

The CHICAGO MEDICAL SOCIETY ANNUAL CLINICAL CONFERENCE should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.

PARKWAY NURSING HOME



1201 PARKWAY AVE.
Trenton, N. J.
Tel. 882-6900

No Steps!
Ranch Type
New audio-visual
call system
from every patient
to Nurses.

One of New Jersey's newest, most modern and completely equipped Nursing and Convalescent Homes, catering to the Convalescent, Aged, and Chronically Ill. Private and Semi-private rooms.

- Referring physician has full medical privileges
- Complete 24-hour general nursing care
- Physical rehabilitation department
- Beauty parlor. Air-conditioned dining room, lounge, and lobby. Spacious patios.
- Ultra modern interiors with artistic color scheme
- Stainless steel kitchen tiled to ceiling
- Special diets. Planned social and recreational activities
- Residential section

REASONABLE RATES — YOUR INSPECTION INVITED

PARKWAY NURSING HOME

Registration Approved by American Hospital Association
Member: Licensed Nursing Homes Assn. of N. J.
Approved to Accept Blue Cross Patients
Member: American Nursing Home Association
NEW JERSEY STATE LICENSED

LONG TERM AUTO LEASING

. . . A SERVICE ESPECIALLY PLANNED FOR DOCTORS!

M.D. PLATES FREE, TOO!

AAL **LONG TERM SINGLE CAR AND FLEET RENTALS**

Call ORange 6-7137 or

MAIL COUPON TODAY

Lease a brand new Cadillac or other fine car from American and you'll never buy again. Save money, time and trouble. One modest monthly payment takes care of everything . . . insurance, maintenance, repairs, depreciation . . . and the payments are 100% tax deductible! Borrow a car—free of charge—in case of accident or breakdown.

INCLUDES

- Registration and plates
- Full maintenance
- Insurance

Liability $250/$500,000
Property damage $20,000
Deductible collision,
fire and theft

AMERICAN AUTO LEASING COMPANY
120 Halsted St., East Orange, N. J.
Please send me the AAL Long Term Leasing Plan.

Wide Selection of '63 Models

Special requirements _____
_____
Name _____
Address _____
City _____ State _____

ALL YOU BUY IS GAS AND OIL

ASK FOR BROCHURE

AAL **AMERICAN AUTO LEASING COMPANY**

120 Halsted Street, East Orange, New Jersey • ORange 6-7137

What's Your Specialty, Doctor?

FRANKLIN CAPITAL CORPORATION

specializes in the mortgage financing of

MEDICAL PROFESSIONAL BUILDINGS

Among projects recently financed:

Suburban Professional Building
Maplewood, 36 suites
New Brunswick Medical Building,
6 suites
Teaneck Medical Building
16 suites
Interstate Medical Center, Ramsey,
6 suites
Irving Professional Building,
10 suites
Medical Arts Building, Jersey City,
30 suites
Kinnelon Medical Center,
8 suites
Kearny Medical Center,
2 suites
East Orange Medical Building,
27 suites
Little Silver Medical Center,
office, therapy buildings

We can finance YOUR project, Doctor! Just call in THE specialist!

FRANKLIN CAPITAL CORPORATION · MORTGAGE BANKERS · FCC · FOUNDED 1927

FRANKLIN CAPITAL
CORPORATION
60 PARK PLACE • NEWARK, N. J. • MARKET 4-8700

Flavoring Improves Palatability of Acidophilus Milk

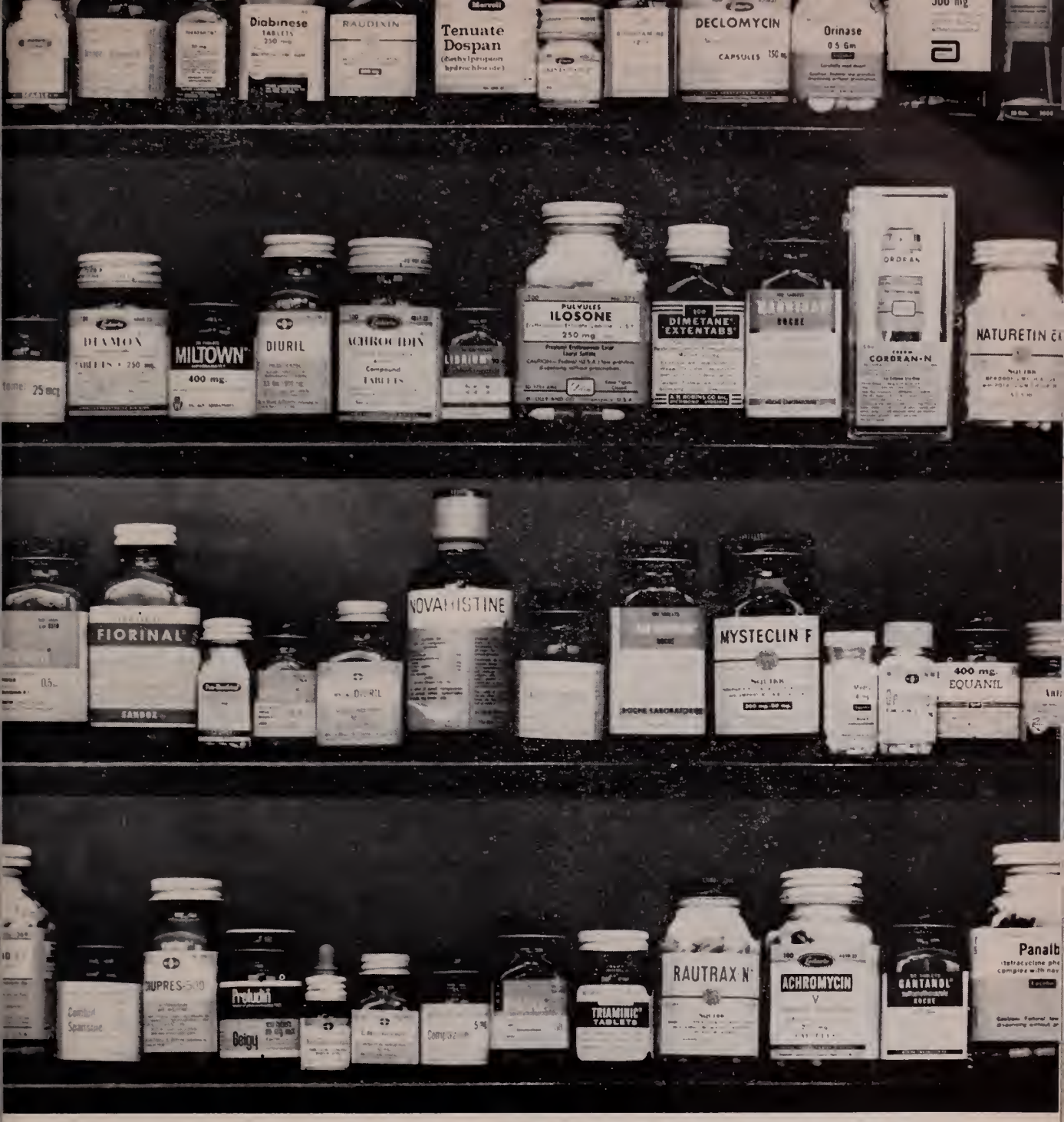
In the treatment of acne vulgaris and such gastro-intestinal disorders as simple chronic constipation and simple diarrhea, patient resistance to ingestion of Acidophilus may be controlled if flavor is improved by stirring 1 to 2 teaspoons of Jell-O powder into each glass of Acidophilus Milk before serving. Most popular flavors are raspberry, cherry, orange-pineapple, blackberry, and strawberry. For patients on low-calorie diets, substitute D-Zerta for Jell-O. Add a few drops of Sweeta or Sweet-10 to the flavored Acidophilus for a sweeter drink.

WALKER-GORDON ACIDOPHILUS

2% butterfat, made from Walker-Gordon Certified Milk cultured with 300-500 million acidophilus bacilli per ml. Available through leading milk dealers.

WALKER-GORDON CERTIFIED MILK FARM, Plainsboro, N. J.

SWinburne 9-1234 (N. Y. WAlker 5-7300; Phila. PEnnypacker 5-3465)



we couldn't begin to get them all into the picture...

Much has been said and more has been written about the quality of, and the motives behind, independent drug research in this country. So we decided to take a look at what we, as an industry, have done in terms of medical progress over the years.

We made a list of the most frequently prescribed drugs of 1962. We gathered them together to take the picture you see on this page. Then we eliminated all products introduced more than 10 years ago. *But then, for the camera to make the labels legible, it became necessary to eliminate several more.*

Just 10 years ago none of these drugs were available for your prescription. How much would it affect your practice if none were available today?

This message is brought to you on behalf of the producers of prescription products.

PHARMACEUTICAL MANUFACTURERS ASSOC. • 1411 K STREET, N.W. • WASHINGTON, D.C.

BRUNSWICK PARK NURSING HOME

NEW JERSEY'S NEWEST, MOST MODERN HOME FOR THE CONVALESCENT, CHRONICALLY ILL AND AGED



NOW OPEN!

NO STEPS TO CLIMB!

REASONABLE RATES

INSPECTION INVITED

- Referring physicians have full medical privileges
- Physical and recreational therapy program
- Experienced professional staff
- Special diets
- Complete 24-hour general nursing care
- Audio-Visual Nurses' call system for every bed
- Air-conditioned
- Private & semi-private rooms
- Sanitary all-stainless steel kitchen, tiled to ceiling
- Tiled wheel-in showers and baths
- Piped-In music
- Spacious outdoor patios

ON U.S. 1 AT INTERSECTION N. J. 18 (Opposite Howard Johnson's)

Tel. (201) 828-2400 Licensed by State of New Jersey **NEW BRUNSWICK, N. J.**

1964 Annual Meeting

The Medical Society of New Jersey

May 16 - 20, 1964

Members are cordially invited to apply for space in the Scientific Exhibits at the 1964 annual meeting.

Applications may be obtained from the Executive offices, P.O. Box 904, Trenton, New Jersey 08605.

SCIENTIFIC EXHIBITS WILL RUN FROM MAY 18 TO MAY 20

CALIFORNIA

INTERVIEWS

NEW YORK CITY—Nov. 15, 16, 18

for Psychiatrists, Internists, General Practitioners, Pediatricians

who are interested in positions with California State Mental Health, Youth Authority and Corrections programs. Starting salaries range from $13,332 to $17,028.

Please write immediately:
Mr. William F. Webster
State Personnel Board
Sacramento, California 95814

YOU *KNOW* how expensive hospital cost can be.

NOW *LEARN* about the broad new protection for your entire family available at new low rates from "The Doctors Company." (No obligation, of course.)

PHYSICIANS MUTUAL INSURANCE COMPANY

formerly

Physicians Casualty and Health Associations

"The Doctors Company"

Insuring Physicians & Dentists for 60 years.

Physicians Mutual Insurance Company
115 So. 42nd Street
Omaha 31, Nebraska

Please send details on your hospital protection plan.

NAME_____ AGE_____

ADDRESS_____

CITY_____ STATE_____



planned by professionals . . .
for professionals . . .
with dignity and fine taste

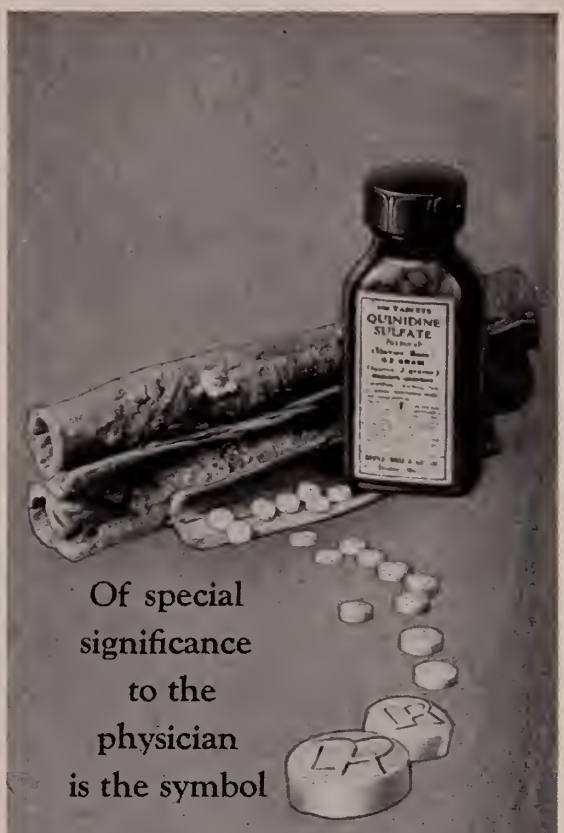
You are invited to visit our extensive showrooms and to discuss your plan with a member of our design staff.

- interior designs
- space planning
- office furniture
- equipment
- accessories

the w.b. wood company

43 clinton street **newark, n. j.**

market 3-7900



Of special significance to the physician is the symbol

When he sees it engraved on a Tablet of Quinidine Sulfate he has the assurance that the Quinidine Sulfate is produced from Cinchona Bark, is alkaloidally standardized, and therefore of unvarying activity and quality.

When the physician writes "DR" (Davies, Rose) on his prescriptions for Tablets Quinidine Sulfate, he is assured that this "quality" tablet is dispensed to his patient.

Rx Tablets Quinidine Sulfate Natural
0.2 Gram (or 3 grains)
Davies, Rose

Clinical samples sent to physicians on request

Davies, Rose & Company, Limited
Boston 18, Mass.

Q-7

CLASSIFIED ADVERTISEMENTS

Send replies to box number, c/o THE JOURNAL
P. O. Box 904, Trenton 5, New Jersey

$5 for 25 words or less; additional words 10c each
Payable in advance of publication

Forms close 15th of the preceding month.

LOCUM TENNENS WANTED—Or other employment for month of December. Young physician between military service and Columbia-Presbyterian residency. Rotating internship and six months medicine residency. G. B. Goode, Jr., M.D., 914 B Oak Street, Fort Devens, Massachusetts.

PSYCHIATRIST—Board eligible, university trained, with 11 years experience, seeks relocation in association, partnership, or group. Write Box No. 81, c/o THE JOURNAL.

GENERAL PRACTITIONER — With extensive training in chest medicine, desire part-time position in hospital, clinic, or other institution. Preferably within the Essex County area. Write Box No. 77, c/o THE JOURNAL.

HOUSE PHYSICIAN OPENINGS—New Jersey licensed or eligible; 250 bed community hospital; JCAH approved; stipend $10,000. Write Box No. 80, c/o THE JOURNAL.

CERTIFIED NEUROLOGIST—Eligible in psychiatry, desires association with a group or individual. Experienced in EEG, EMG, angiography, myelography, etc. New Jersey license. Write Box No. 79, c/o THE JOURNAL.

PHYSICIAN WANTED—Client with large medical-surgical practice in small group seeking energetic beginner in internal or general medicine for eventual co-partner. First year salary—$15,000. Confidences maintained for all concerned until real interest is developed. Medical Business Bureau, 5 Beekman Street, New York 38, New York.

E.N.T. SPECIALIST—Thirty years in practice. Home, office, records for sale. Elizabeth, New Jersey. Recently deceased. EL 4-5307.

PRACTICE FOR SALE—Very busy old general medical practice in Northern New Jersey. Sudden death of physician. Beautiful, modern air-conditioned office for rent. Mrs. Archie Ged. 711 Alps Road, Wayne, New Jersey. OX 4-4823.

UNUSUAL OPPORTUNITY FOR NEGRO DOCTOR—Physician 54 years in practice, retiring. Willing to sell same and rent office and apartment. Office consists of large waiting-room, consultation room, and three work rooms. Air-conditioned, fully equipped, x-ray, Basal, new tables and instruments. Must be seen to be appreciated. Reasonable arrangements. Call ES 2-7711 or 774-1969.

LABORATORY TECHNICIAN—For internist's office. Part or full time. No evenings. J. F. Pessel, M.D., 224 West State Street, Trenton, New Jersey.

PHYSICIAN WANTED—to do general medicine and minor sugrery in Medical Unit and Psychiatric Service of 1000 bed institute. To work with two other generalists under immediate supervision of Board Certified Internist. Salary range $7,737 - $10,059 if no New Jersey license. Salary range $10,887 - $14,151 if New Jersey license. Foreign medical graduates must have ECFMG certificate. Reply: Robert E. Bennett, M.D., Medical Director, N. J. Neuro-Psychiatric Institute, Box 1000, Princeton, New Jersey.

GENERAL PRACTITIONER—Small group. Northern New Jersey metropolitan area. Experienced. Salary with eventual partnership. Internist would also be considered. Write Box No. 78, c/o THE JOURNAL.

PRACTICE FOR SALE—25-year-old practice for internist or general practitioner in Monmouth County, New Jersey; beautiful 5-year-old brick home and large 5½ rooms office; including 100 Ma. x-ray, all new equipment, air-conditioned. Sudden death of physician. Gross well over $50,000. Financing arranged or salary basis. H. M. Swartz, M.D., 138 Cherry Tree Farm Road, Middletown, New Jersey. OS 1-3313.

OFFICE TO SHARE—Upper Montclair. Completely equipped, air-conditioned, 500 ma. x-ray, EKG, etc. PI 4-3636.

POSITION WANTED—Medical Assistants and Secretaries. Laboratory and X-Ray Techs. Well-trained and highly qualified personnel (male and female) available. Phone CH 2-2330, Ext. 17, Placement Department, or write Physician Director, Eastern School for Physicians' Aides, Department 7, 85 Fifth Avenue, New York 3, New York.

PHYSICIAN'S OFFICE—For sublease in attractive Weequahic section of Newark, New Jersey. Available November 1st. Located in a six story modern apartment house, facing park. Office fully air-conditioned, twelve hundred square feet at less than $2.00 per square foot. Efficiently divided into large waiting room with nurse's station and large laboratory space, attractive consultation room, four treatment rooms, storage space, two entrances. Please call WA 3-4861 for appointment to inspect.

CLASSIFIED (Continued)

FOR SALE—North Bergen, New Jersey. Established doctor's home and office (pediatrician) in finest residential location, convenient to New York. Solid brick colonial, 12 rooms, custom built, modern kitchen, 62 x 100, beautifully andscaped. Highly desirable for specialized practice. Telephone: UN 9-2440.

MEDICAL OFFICE—600 square feet, 3 examining rooms, consultation room, waiting room, all necessary utilities, air-conditioned, heated, unlimited parking, immediate occupancy. Menlo Park Shopping Center Office Building, Telephone LI 9-1900 or write P.O. Box 188, Iselin, New Jersey.

IRVINGTON—600 square foot suite remaining in new professional building, presently occupied by dentist, allergist, optometrist, and speech therapist. 1146 Stuyvesant Avenue. ES 3-1073, MU 6-0787.

FOR RENT—Medical building. Growing area near Pascack Valley, Good Samaritan, and Ramapo General Hospitals. 700 square feet. Renovate to suit. Central air-conditioning. Parking. Phone: 201-GE-8-4350; evening 201-TW-1-4270; or write S. J. Spasaro, 790 Paterson Avenue, East Rutherford, New Jersey.

OFFICE SPACE—Monmouth County, small, new, professional building adjoining pharmacy. Excellent potential. Interior designed to suit. Nominal rent, lease arranged to your needs. Rapidly growing area. Parking. Steven Drugs, Monmouth Road, West Long Branch, New Jersey; 222-4411.

MEDICAL ARTS BUILDING—Tenafly, Corner County Road & Central Avenue. Immediate occupancy. Modeled to suit your needs without extra charge. All maintenance services included. Elevator. Central air-conditioning. Covered on-site parking. Convenient to hospitals. 24 hour service. Call—Day: DE 3-7700; Eves: (NY) MA 1-4035.

INQUIRIES INVITED—From senior doctors seeking associates; also from beginning doctors seeking eventual partnership. Assistance provided in partnership and group formations by professional business consultants. Available for purchase — E.N.T. practice, reasonable, with excellent potential. Medical-Dental Search Services, 5 Beekman Street, New York 38, New York.

The Standard of Quality for Over Thirty Years

MILLSIDE FARMS

Distributors of

Milk and Milk Products
for the Home and Store

U. S. Route 130
RIVERSIDE, N. J.

Visit our Modern Dairy Barn

HObart 1-0046

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem. KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.



KOAGAMIN®

parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenal 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

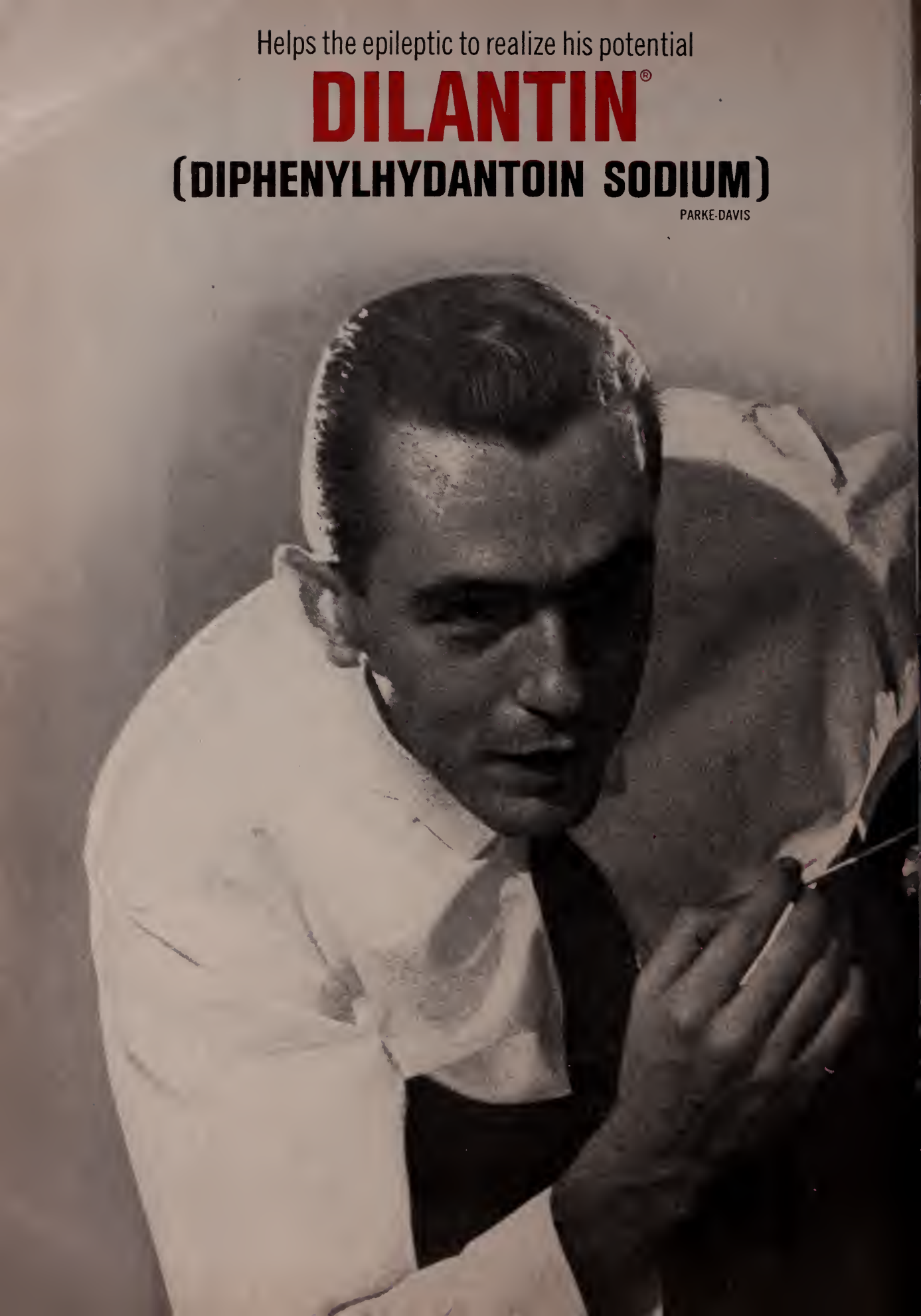
CHATHAM PHARMACEUTICALS, INC.
Newark 2, New Jersey
Distributed in Canada by Austin Laborotories, Ltd. • Paris, Ontario

Helps the epileptic to realize his potential

DILANTIN®

(DIPHENYLHYDANTOIN SODIUM)

PARKE-DAVIS



"The most effective form of emotional approach remains the demonstration to the patient that the seizure phenomena can be adequately controlled with anticonvulsant medication."[1]

At present, diphenylhydantoin sodium is generally regarded as the standard in anticonvulsant medication because of its effectiveness in controlling grand mal and psychomotor seizures.[2-10] It possesses a wide margin of safety, and incidence of side effects is minimal.[4] With this agent, oversedation is not a problem.[3] Moreover, its use is often accompanied by improvement in the patient's memory, intellectual performance, and emotional stability.[11]

Indications: Grand mal epilepsy and certain other convulsive states.

Precautions: Toxic effects are infrequent: allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Eruptions then usually subside. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Megaloblastic anemia has been reported. Nystagmus may develop. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. Periodic examination of the blood is advisable.

DILANTIN Sodium (diphenylhydantoin sodium) is available in several forms including Kapseals,® 0.03 Gm. and 0.1 Gm., bottles of 100 and 1,000.

REFERENCES: (1) Hammill, J. F.: J. Chron. Dis. 8:448, 1958. (2) Roseman, E.: Neurology 11:912, 1961. (3) Bray, P. F.: Pediatrics 23:151, 1959. (4) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (5) Crawley, J. W.: M. Clin. North America 42:317, 1958. (6) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (7) Ibid.: Postgrad. Med. 20:584, 1956. (8) Merritt, H. H.: Brit. M. J. 1:666, 1958. (9) Carter, C. H.: Arch. Neurol & Psychiat. 79:136, 1958. (10) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (11) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.

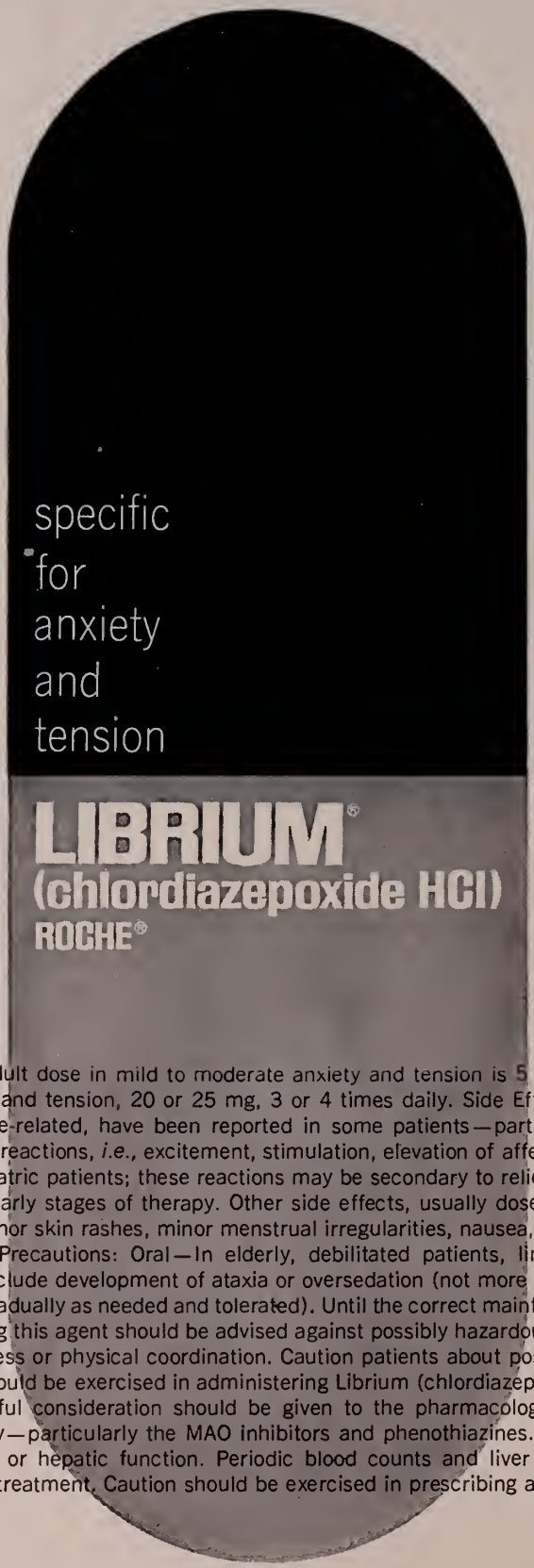
14863

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan



ROCHE



Dosage: Oral—Usual adult dose in mild to moderate anxiety and tension is 5 or 10 mg, 3 or 4 times daily; in severe anxiety and tension, 20 or 25 mg, 3 or 4 times daily. Side Effects: Oral—Drowsiness and ataxia, usually dose-related, have been reported in some patients—particularly the elderly and debilitated. Paradoxical reactions, *i.e.*, excitement, stimulation, elevation of affect and acute rage, have been reported in psychiatric patients; these reactions may be secondary to relief of anxiety and should be watched for in the early stages of therapy. Other side effects, usually dose-related, have included isolated instances of minor skin rashes, minor menstrual irregularities, nausea, constipation, increased and decreased libido. Precautions: Oral—In elderly, debilitated patients, limit dosage to smallest effective amount to preclude development of ataxia or oversedation (not more than 10 mg per day initially, to be increased gradually as needed and tolerated). Until the correct maintenance dosage is established, patients receiving this agent should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Caution patients about possible combined effects with alcohol. Caution should be exercised in administering Librium (chlordiazepoxide HCl) to addiction-prone individuals. Careful consideration should be given to the pharmacology of any agents to be employed concomitantly—particularly the MAO inhibitors and phenothiazines. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests may be advisable in protracted treatment. Caution should be exercised in prescribing any therapeutic agent to pregnant patients.

THE Journal OF

THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since 1904
Copyright 1963 by The Medical Society of New Jersey

Entered as second-class matter Sept. 5, 1906, at the post office, Orange, N. J., under Act of March 3, 1879
Second-Class Postage Paid at Orange, N. J.

VOL. 60, NO. 11 NOVEMBER, 1963 50 Cents - $5.00 PER YEAR

NOV 25 1963
LIBRARY

CONTENTS—Pages 497 to 536

EDITORIALS— Page

Total Information and Psychic Injury 497

Doctors, Politics, and Government 498

ORIGINAL ARTICLES—

Chronic Fatigue—Harvey E. Nussbaum, M.D., Newark 499

Drinking Water and Heart Failure—Peter Braun, M.D., Trenton and Alvin A. Florin, M.D., South Orange 504

Rupture of the Gravid Uterus—Margaret Brisco, M.D., and Gerard Cicalese, M.D., Newark 510

Clinical Indications for Electromyography—Charles A. Furey, M.D., Lakeland 514

Oophorectomy in Cancer of the Bowel—Dave B. Swerdlow, M.D., and Lawrence Ulvestad, M.D., Orange 518

ORIGINAL ARTICLES— Page

Septic Abortion in Bacteremia—Edward J. Bookrajian, M.D., North Bergen 520

Deaths Due to Septic Abortion — John D. Preece, M.D., Trenton 523

PSYCHOSOMATIC PROFILE 524

STATE ACTIVITIES—

Medical Defense Course 517

Trustees' Minutes: September 15, 1963 525

Special and Liaison Representatives, and Special Committees 528

ANNOUNCEMENTS 532

OBITUARIES 533

BOOK REVIEWS 534

RESPIRATORY DISEASE ABSTRACTS 535

Roster of Officers, 3 A

The Medical Society of New Jersey

Endorsed Insurance Plans

ACCIDENT AND HEALTH INSURANCE

$ 1,200 a month new maximum Basic total disability benefit

ACCIDENT: from 1st day, up to 5 years (Partial Accident Disability, half benefit up to six months)
SICKNESS: from 8th day, up to 2 years

$600 a month new maximum Extended total disability benefit, continuing benefits beyond basic coverage.

ACCIDENT: extended to LIFE
SICKNESS: extended through SEVENTH year

MAJOR MEDICAL EXPENSE INSURANCE

$10,000 maximum for Covered Expenses for each accident or sickness, covering member, spouse, and eligible children. Plan pays 80% Covered Expenses after $500 deductible.

LIFE INSURANCE

$10,000 to **$50,000** of Convertible Term Life Insurance.

(Guaranteed exchangeable at any time into Permanent Cash Value life insurance without medical examination)

Applications for initial $10,000 policy and additional $10,000 policies up to $50,000 total under this plan considered during the month of November each year.

SIX POINT, HIGH LIMIT ACCIDENT INSURANCE

Up to $200,000 for member, covering accidental death, dismemberment, loss of sight, total and permanent disability, exposure and disappearance.

Up to $100,000 for spouse (without disability benefit).

Applications are subject to age limits and other company rules and regulations for acceptance of risk. New members have special privileges during the first few months of membership; ask for specific details if you were recently elected and have not received notification from us.

Information and claim service are as close as your telephone.

E. & W. BLANKSTEEN

E. & W. Blanksteen Agency, Inc.

75 MONTGOMERY STREET JERSEY CITY, NEW JERSEY 07302

DElaware 3-4340 (Area Code 201)

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATON, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.
EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154
(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

OFFICERS

President, Jerome G. Kaufman, M.D. ..... Maplewood
President-Elect, Charles H. Calvin, M.D. ..... Perth Amboy
First Vice-President, John J. Bedrick, M.D. .....Bayonne
Second Vice-President, Joseph R. Jehl, M.D. ..... Clifton
Secretary, Marcus H. Greifinger, M.D. .....Newark
Treasurer, Daniel F. Featherston, M.D. ..... Asbury Park

Richard I. Nevin, *Executive Director* ..... Trenton
Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton

TRUSTEES

Samuel J. Lloyd, M.D., *Chairman* (1966) ..... Trenton
Nicholas A. Bertha, M.D., *Secretary* (1965) ..... Wharton
Jerome G. Kaufman, M.D. ..... Maplewood
Charles H. Calvin, M.D. ..... Perth Amboy
John J. Bedrick, M.D. ..... Bayonne
Joseph R. Jehl, M.D. ..... Clifton
Marcus H. Greifinger, M.D. ..... Newark
Daniel F. Featherston, M.D. ..... Asbury Park
Louis S. Wegryn, M.D. ..... Elizabeth
Louis F. Albright, M.D. (1964) ..... Spring Lake
Louis K. Collins, M.D. (1964) ..... Glassboro
Thomas C. DeCecio, M.D. (1965) ..... Cliffside Park
Joseph P. Donnelly, M.D. (1966) ..... Jersey City
Lloyd A. Hamilton, M.D. (1965) ..... Lambertville
Frank J. Hughes, M.D. (1966) ..... Gloucester
John F. Kustrup, M.D. (1966) ..... Trenton
Emanuel M. Satulsky, M.D. (1964) ..... Elizabeth
Carl N. Ware, M.D. (1965) ..... Ocean City

COUNCILORS

First District (Essex, Morris, Union, and Warren Counties) ..... Thomas S. P. Fitch, M.D., Plainfield (1966)
Second District (Bergen, Hudson, Passaic, and Sussex Counties) ..... John L. Olpp, M.D., Englewood (1965)
Third District (Hunterdon, Mercer, Middlesex, and Somerset Counties) ..... Albert F. Moriconi, M.D., Trenton (1964)
Fourth District (Burlington, Camden, Monmouth, and Ocean Counties) ..... E. Vernon Davis, M.D., Moorestown (1966)
Fifth District (Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties) .... Isaac N. Patterson, M.D., Westville (1965)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell, M.D. (1964) ..... Asbury Park
William F. Costello, M.D. (1963) ..... Dover
Joseph P. Donnelly, M.D. (1965) ..... Jersey City
Marcus H. Greifinger, M.D. (1964) ..... Newark
Luke A. Mulligan, M.D. (1964) ..... Leonia
Isaac N. Patterson, M.D. (1965) ..... Westville

Alternates

F. Clyde Bowers, M.D. (1964) ..... Mendham
Frank J. Hughes, M.D. (1964) ... . Gloucester
Joseph R. Jehl, M.D. (1965) ..... Clifton
John F. Kustrup, M.D. (1964) ..... Trenton
Elton W. Lance, M.D. (1965) ..... Rahway
John L. Olpp, M.D. (1963) ..... Englewood

DELEGATES TO OTHER STATES

New York—William F. Costello, M.D. (1963) ..... Dover
Connecticut—Lloyd A. Hamilton, M.D. (1963) .. Lambertville
New York—G. Ruffin Stamps, M.D. (1963) .... Atlantic City
Connecticut—S. Eugene Dalton, M.D. (1963) ..... Ventnor

Scientific Exhibits — 1964 Annual Meeting

Members are invited by the Committee on Annual Meeting and its Subcommittee on Scientific Exhibits to present scientific exhibits at the 198th Annual Meeting next May in Atlantic City. The exhibits will run from 9:00 a. m. on Monday, May 18, to 3:00 p. m. on Wednesday, May 20, 1964.

The Subcommittee will accept applications up to, and including, December 16, 1963, following which the scientific exhibits will be selected.

Applications may be obtained from the Executive Offices of MSNJ, P. O. Box 904, Trenton, New Jersey 08605. Write for yours now.



Helps speed recovery even in severe muscle injuries

Whether your muscle-injury patient is a professional athlete or just a weekend golfer, you can expect rapid results with 'Soma' (carisoprodol).

This unique drug breaks up both muscle spasm and pain at the same time. Onset of action takes only 30 minutes, and your patient will usually begin to feel better within hours.

As Conant demonstrated in a study of 106 patients with musculoskeletal injuries, 88% of the patients treated with 'Soma' (carisoprodol) achieved good to excellent results. *(Clinical Medicine*, March, 1962.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely. For severe athletic strains or everyday sprains, you can rely on 'Soma' (carisoprodol) to help speed recovery with notable safety.

USUAL DOSAGE: ONE 350 MG. TABLET Q.I.D.

The muscle relaxant with
an independent pain-relieving action

Soma®
carisoprodol

Wallace Laboratories, Cranbury, New Jersey

★ ★ ★ ★ ★

Milestones in Nutrition

1952

when protein was missing...

. . . they turned to milk. In 1952 a team of United Nations investigators tried using dried milk to treat a widespread disease of children in central Africa. Milk was effective . . . thanks to its liberal content of high quality protein.

Aside from calories, protein deficiency is probably the most common deficiency disease of man. It usually occurs after weaning . . . when the child changes to a cereal diet consisting mostly of carbohydrate. Milk is the most effective source of protein during early therapy.

Because of the liberal amounts of protein in our diets, protein deficiency is seldom seen in the United States. The high quality of milk protein . . . its relative abundance and moderate cost . . . have been important factors in assuring an adequate protein intake.

As they have in the past, milk and other dairy foods will continue to play a vital role in the nutritional welfare of our people.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion. .



Since 1915 . . . promoting better health through nutrition research and education

NATIONAL DAIRY COUNCIL

a non-profit organization

202 EAST 44TH STREET · NEW YORK 17, NEW YORK

AVAILABLE ON REQUEST: Reprints of this series of messages on "MILESTONES IN NUTRITION" and "CLINIC LEAFLETS" ON PRE-NATAL, POST-NATAL, AND INFANT CARE

Colds haven't changed— but relief has with NTz® NASAL SPRAY

NTz Nasal Spray gives on-the-spot relief for stopped-up noses instantly. Recommended by doctors for 10 years, it provides not one, but three powerful ways to fast relief.

In a carefully balanced formula, NTz contains:

Neo-Synephrine® HCl to shrink swollen nasal tissues and provide enough space for breathing

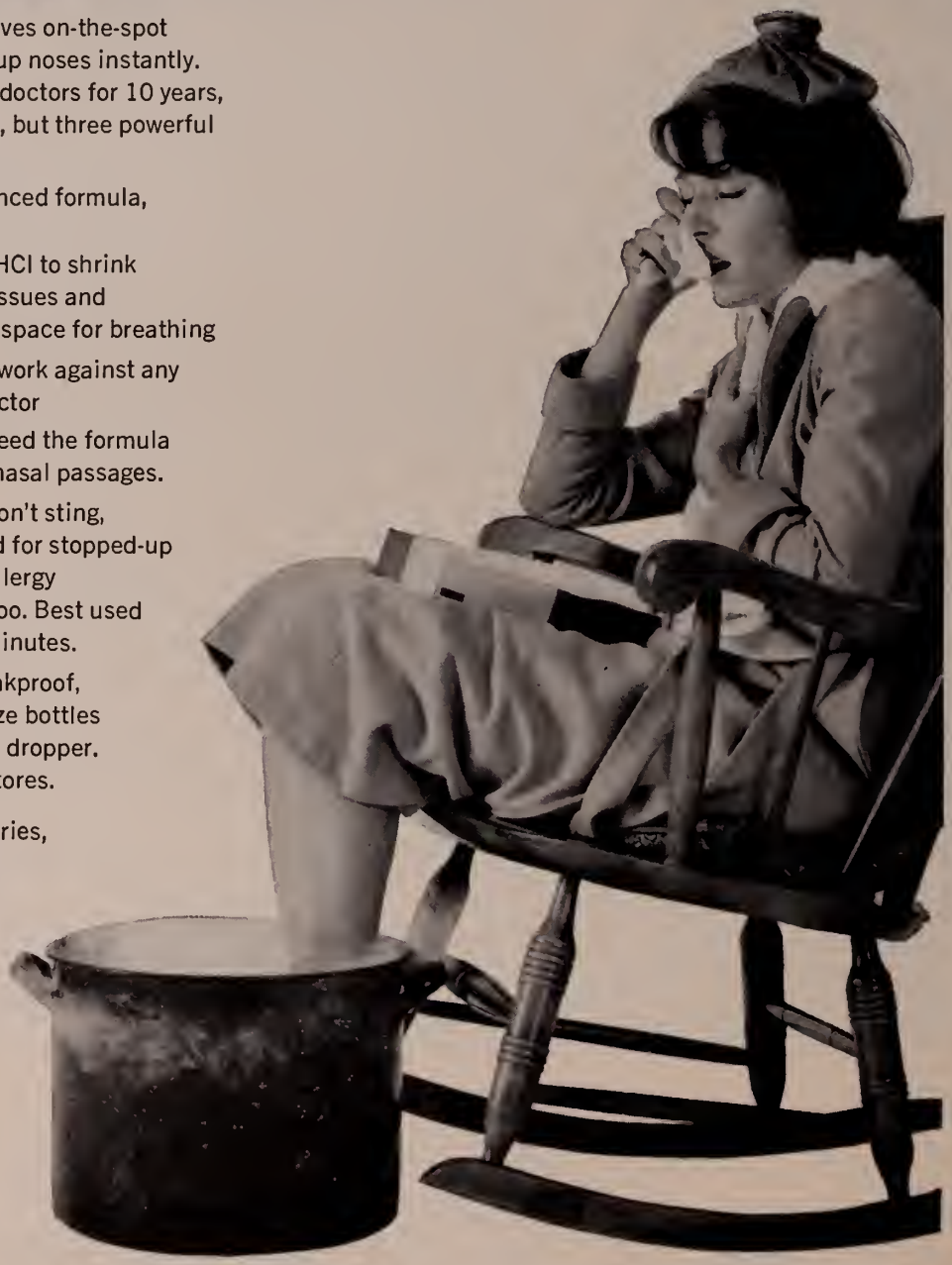
Thenfadil® HCl to work against any local allergic factor

Zephiran® Cl to speed the formula through **all** the nasal passages.

NTz Nasal Spray won't sting, won't irritate. Good for stopped-up noses caused by allergy and for sinusitis, too. Best used **twice** within five minutes.

NTz supplied in leakproof, pocket-size squeeze bottles and in bottles with dropper. Sold only in drugstores.

Winthrop Laboratories,
New York 18, N. Y.



Winthrop

NTz, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U. S. Pat. Off.

Important news in cardiac therapy

Two new clinical reports document successful long-term treatment of ischemic heart disease with

Persantin®, brand of dipyridamole

See next 3 pages

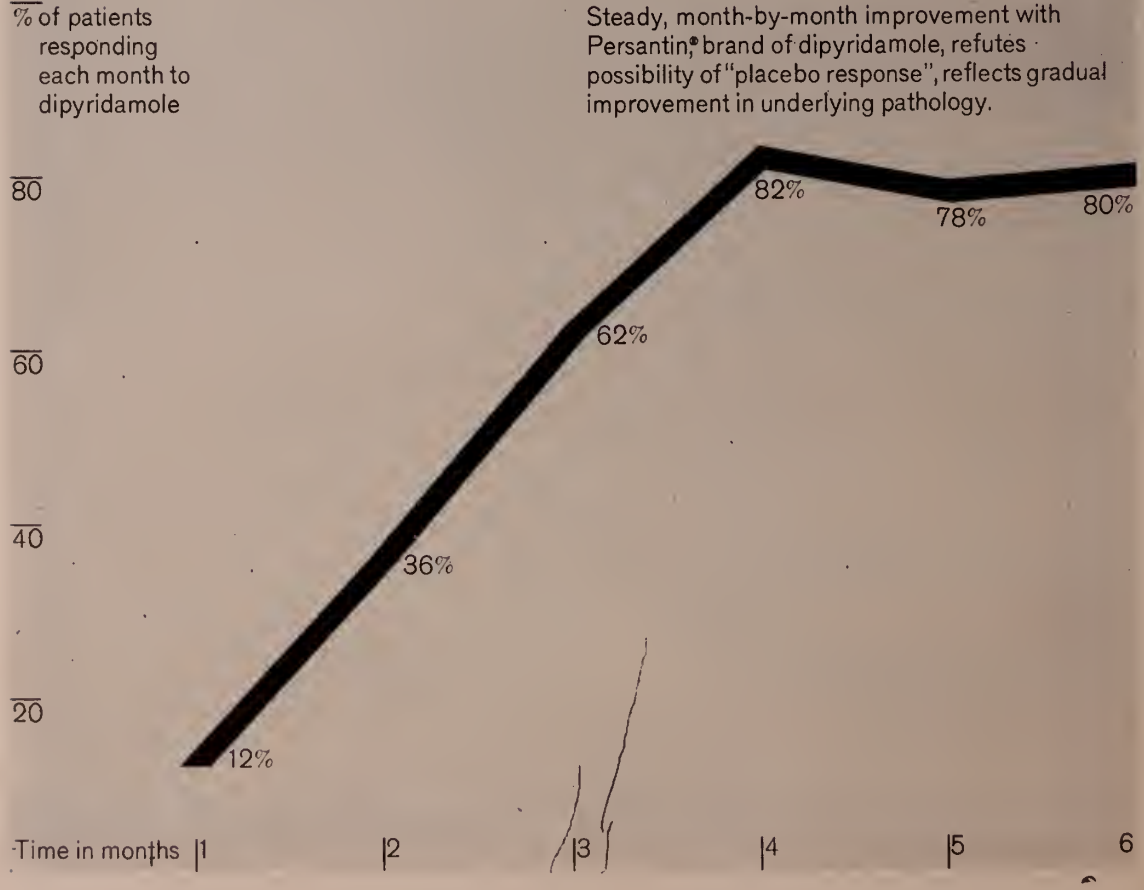
Study 1.
Griep,A.H.: Long-term Therapy of Ischemic Heart Disease With Oral Dipyridamole: A Report of Fifty Cases. Angiology 14:484, 1963.

Persantin,® brand of dipyridamole, 25 mg. t.i.d. or q.i.d.,was administered continuously for 6 months to 50 patients with well authenticated ischemic heart disease with angina pectoris and ECG abnormalities. Results were evaluated on a monthly basis.

Persantin® brand of dipyridamole

"...long-term oral therapy with dipyridamole was of benefit in 80 per cent of the patients...

"relief [of angina] came slowly and was usually maximal after three to six months of continuous treatment"



Steady, month-by-month improvement with Persantin,® brand of dipyridamole, refutes possibility of "placebo response", reflects gradual improvement in underlying pathology.

Study 2.
Wirecki,M.: Dipyridamole (Persantin®): Evaluation of Long-Term Therapy in Angina Pectoris. Current Therapeutic Research 5:472, 1963.

In 40 ambulatory patients with myocardial ischemia, angina pectoris, and abnormal ECG findings, Persantin,® brand of dipyridamole, 25 mg. t.i.d., was administered continuously for 3 months.

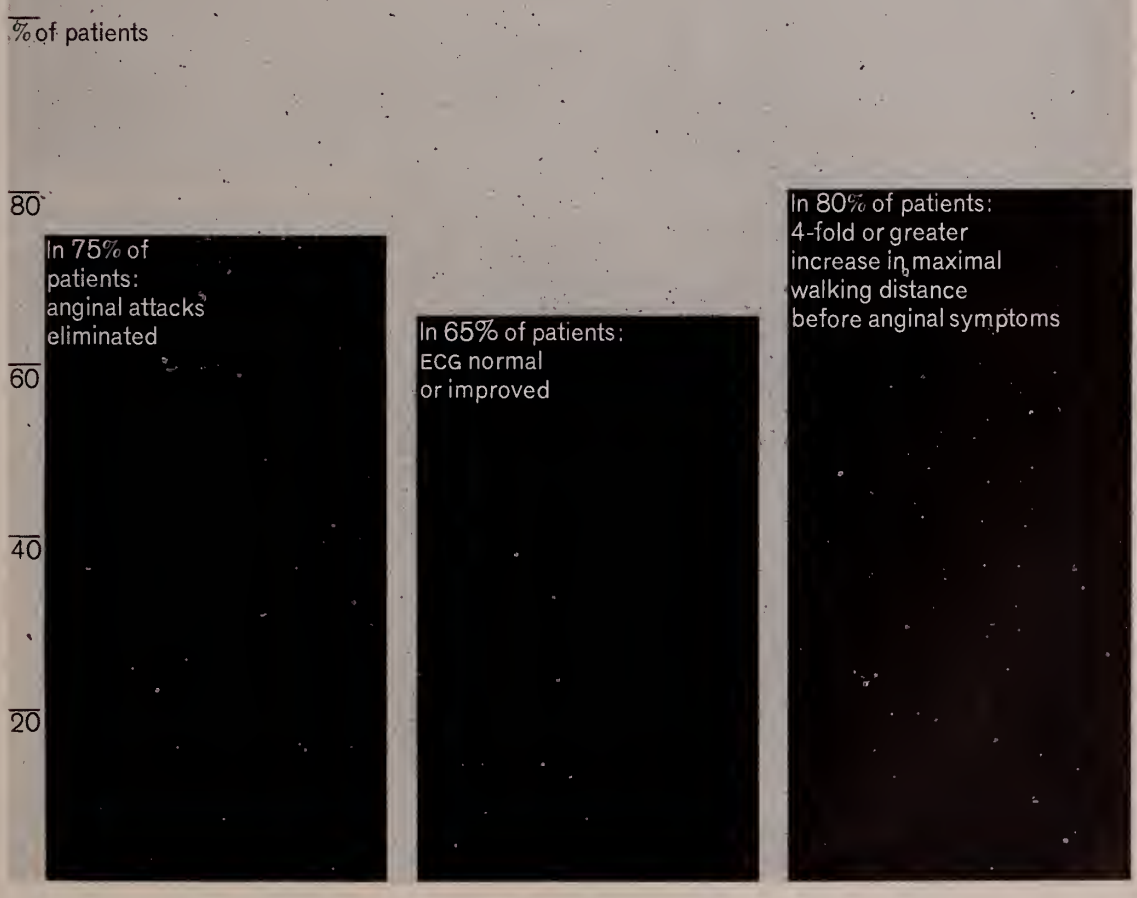
Geigy

After 3 months, 32 of 40 patients showed:

"...reduction or abolition of acute anginal attacks...

"complete or almost complete disappearance of ECG abnormalities...

"marked increase" in walking distance without anginal symptoms



Persantin® brand of dipyridamole

How long-term therapy provides clinical benefits reported on previous pages

1. By increasing energy yield
of the hypoxic myocardial cell, by direct action upon the sarcosomes (heart mitochondria).[1-5]

2. By improving collateral coronary circulation.
Prolonged oral administration of dipyridamole to animals with experimentally induced stenosis of a major coronary artery resulted in superior development of collateral coronary anastomoses and longer survival compared with controls.[6-9]

When given for prolonged periods and in adequate dosage, dipyridamole improves the coronary flow deficit of the ischemic myocardium while supporting cardiac metabolism during the period of repair. Clinically, this is manifested as steady improvement – anginal attacks diminish in frequency and intensity, as do other manifestations of insufficiency (dyspnea, fatigue, and, in many instances, abnormal electrocardiographic findings).

Availability:
Tablets of 25 mg., bottles of 100 and 1000.
Under license from Boehringer Ingelheim G.m.b.H.

Prescribing summary: Persantin,® brand of dipyridamole, is indicated in coronary and myocardial insufficiency, in a dosage of 2 to 6 tablets daily in divided doses before meals for several weeks. Side effects (headache, dizziness, nausea, flushing, weakness, syncope, mild gastrointestinal distress) are minimal and transient. The drug is not recommended in the acute phase of myocardial infarction, and should be used cautiously in hypotension.

References: 1.Kunz,W.;Schmid,W.,and Siess,M.: Arzneimittel-Forsch.12:1098,1962. 2.Siess,M.: Arzneimittel-Forsch.12:683,1962. 3.Laudahn,G.: Experientia 17:415,1961. 4.Lamprecht,W.: 27th Congress of the German Society for Circulation Research,Bad Nauheim,1961. 5.Hockerts,T.,and Bögelmann,G.: Arzneimittel-Forsch.9:47,1959. 6.Vineberg,A.M.,et al.: Canad.M.A.J.87:336,1962. 7.Chari,S.R.,et al.: Presented at the International Congress of Chest Physicians,New Delhi,1963. 8.Neuhaus,G.,et al.: Presented at the Fourth World Congress of Cardiology,Mexico City,1962. 9.Asada, S.,et al.: Japanese Circ.J.26:849,1962.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York, Distributors
PE-2290



for fast and long-lasting cough control

HYCOMINE® SYRUP

Each teaspoonful (5 cc.) contains:

Hycodan®	
Hydrocodone bitartrate . . 5 mg.	
(Warning: May be habit-forming)	6.5 mg.
Homatropine methylbromide 1.5 mg.	
Pyrilamine maleate	12.5 mg.
Phenylephrine hydrochloride	10 mg.
Ammonium chloride	60 mg.
Sodium citrate	85 mg.

in a highly palatable, cherry-flavored vehicle (methylparaben 0.13% and propylparaben 0.02% as preservatives)

INDICATIONS: For both productive and nonproductive cough. For relief of symptoms in tracheitis, bronchitis, pneumonia, pharyngitis, bronchial asthma, pertussis, and allied conditions; cough associated with allergy; in general, whenever cough medication is indicated.

DOSAGE: Average adult dose—1 teaspoonful after meals and at bedtime with food. Children 6 to 12 years, ½ teaspoonful; 3 to 6 years, ¼ teaspoonful; 1 to 3 years, 10 drops; 6 months to 1 year, 5 drops; after meals and at bedtime. On oral Rx where state laws permit. U.S. Pat. 2,630,400.

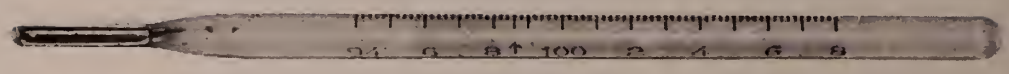
CAUTION: Should be used with caution in patients with known idiosyncrasies to phenylephrine HCl and in patients with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients use should not exceed three days. Hycomine Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur. May be habit-forming.

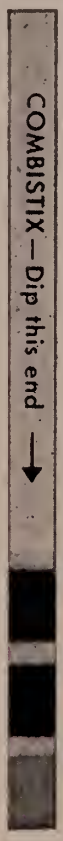
Endo

Literature on request

ENDO LABORATORIES Richmond Hill 18, New York

one answer... three minutes





three answers ...ten seconds

DIP AND READ

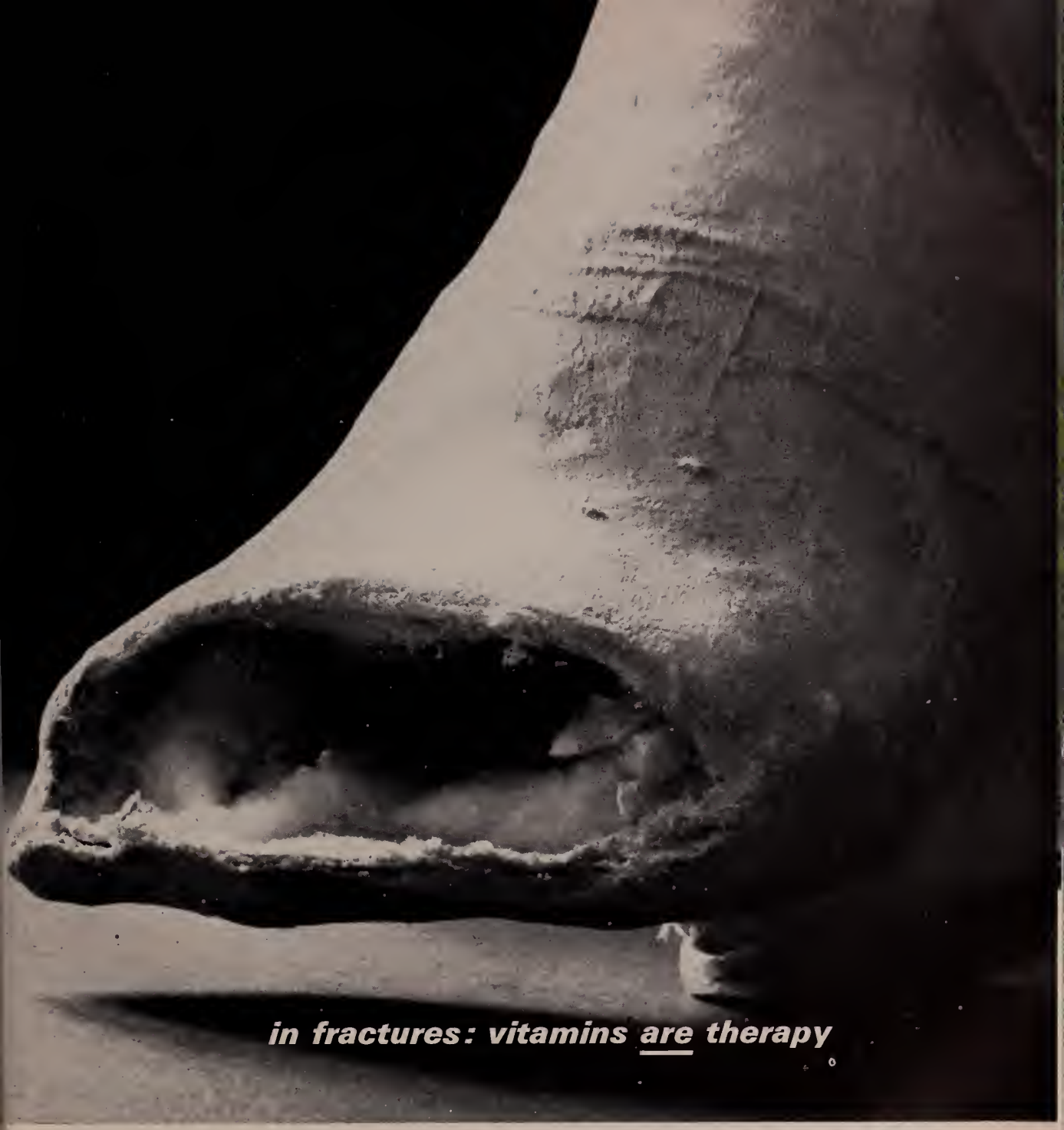
combistix®

urine protein • glucose • pH

BASIC COMBINATION TEST FOR BEDSIDE AND OFFICE

... faster than taking temperature. Detects glucosuria (as in diabetes), proteinuria (as in renal disorder), abnormal pH (as in calcinosis or GU infection). For routine screening of all patients.
COMBISTIX—*basic as the stethoscope.*
AMES products are available through your regular supplier. 38263

AMES
COMPANY INC
Elkhart • Indiana
Toronto • Canada



Few factors are more fundamental to tissue and bone healing than nutrition. Therapeutic allowances of B and C vitamins are important for rapid replenishment of vitamin reserves which may be depleted by the stress of fractures. Metabolic support with STRESSCAPS is a useful adjunct to an uneventful recovery.

FOR PROFESSIONAL

RECOMMENDATION-ONLY

Each capsule contains: Vitamin B_1 (Thiamine Mononitrate)...10 mg. / Vitamin B_2 (Riboflavin)...10 mg. / Niacinamide... 100 mg. / Vitamin C (Ascorbic Acid)...300 mg. / Vitamin B_6 (Pyridoxine HCl)...2 mg. / Vitamin B_{12} Crystalline... 4 mcgm. / Calcium Pantothenate...20 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

6317-1

STRESSCAPS®

Stress Formula Vitamins Lederle

"What type of drug is both a tranquilizer and a muscle relaxant?"

"a tranquilaxant."

TRANCOPAL®

brand of

chlormezanone

is a tranquilaxant

As a tranquilizer, TRANCOPAL (chlormezanone-Winthrop) "is effective in the symptomatic treatment of anxiety."[1] Its tranquilizing properties are similar to those of other mild tranquilizers. Furthermore, it relieves tension of both mind and muscle without interfering with normal activity or alertness.

The muscle relaxant properties of this drug provide an extra dimension of effectiveness... relaxing the spasm which so frequently accompanies psychogenic disorders. Hence, the total therapeutic effect of this true "tranquilaxant" is to produce a relaxed mind in a relaxed body.

Unsurpassed Tolerance: Less than 3 per cent of patients develop side effects with TRANCOPAL (chlormezanone-Winthrop), such as occasional drowsiness, dizziness, flushing, nausea, depression, weakness and drug rash. If severe, medication should be discontinued. In most patients, however, side effects are minor and do not necessitate interruption of treatment. There are no known contraindications.

Available: 200 mg. Caplets® (green colored, scored). 100 mg. Caplets (peach colored, scored), each in bottles of 100.

Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; in some patients 100 mg. three or four times daily suffices. Children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Reference: 1. A.M.A. Council on Drugs: J.A.M.A. 183:469 (Feb. 9) 1963.

1912M

Winthrop

WINTHROP LABORATORIES
New York, N. Y.



winter coughs ahead...
clear the tract with Robitussin®

ROBITUSSIN®
Each 5 cc. tsp. contains:
Glyceryl guaiacolate ..... 100 mg.

ROBITUSSIN® A-C
Robitussin with antihistamine and codeine.
Each 5 cc. tsp. contains:
Glyceryl guaiacolate ..... 100 mg.
Pheniramine maleate ..... 7.5 mg.
Codeine phosphate ..... 10 mg.
(exempt narcotic)

Photo: N. & W. Engine No. 611, last of the famous "Class J" locomotives, on its final run between Roanoke, Va., and Williamson, W. Va., Oct. 26, 1959.



For the coughing patient who labors to remove tenacious mucus from his respiratory tract, Robitussin provides a remarkably potent expectorant action. It contains glyceryl guaiacolate which increases respiratory tract fluid (R.T.F.) almost 200% to "clear the tract" of cough-inducing irritants. Increased R.T.F. also permits more efficient action of bronchial and tracheal cilia to further enhance the evacuation of sputum, thus reducing cough frequency and helping the cough remove its cause.

After more than thirteen years and millions of prescriptions, no serious side effects have been reported from Robitussin. And patient acceptance has been outstanding.

A. H. ROBINS COMPANY, INC., Richmond 20, Virginia

This is the season Allbee® with C is made for!



When a good old-fashioned winter proves too much for your modern-day patients, it's a comfort to know about Allbee with C. Consider its simple, rational, economical formula when patients need therapeutic amounts of B and C vitamins during the "flu" and u.r.i. season. **This is what Allbee with C is made of:** Thiamine mononitrate (B_1), 15 mg.; Riboflavin (B_2), 10 mg.; Pyridoxine HCl (B_6), 5 mg.; Nicotinamide, 50 mg.; Calcium pantothenate, 10 mg.; Ascorbic acid (vitamin C), 300 mg.

A. H. Robins, Co., Inc. Richmond 20, Va.

HOW TO WIN FRIENDS...

little



New
Orange Flavored
Bayer Aspirin for Children
is sweet
all the way through,
so children
take it readily.
The GRIP-TIGHT CAP ----------
on the bottle
helps keep them
from taking it
on their own.

Bottles of 50 tablets
(1¼ grains each)

NOW!
NEW ORANGE FLAVOR!

We will be pleased to send
professional samples on request.

THE BAYER COMPANY
Division of Sterling Drug Inc., Dept. 112
1450 Broadway, New York 18, N.Y.

COSMEDICAKE®

© 1963 Pat. Applied For

greaseless dehydrated lotion in
cake make-up form





3-way benefits
in acne, facial seborrhea

❶ antibacterial action
...to combat many common pathogenic skin microorganisms

❷ mild astringent and keratolytic efficacy
...to aid removal of excess sebaceous material and keratinization

❸ effective blemish concealment
...to help minimize emotional distress often occasioned by cosmetic defects

COSMEDICAKE is specially formulated as adjunctive therapy for skin eruptions of cosmetic importance in female patients. Extensive clinical experience confirms its 3-way benefits. In 88% of 112 female patients with acne vulgaris or acne rosacea, COSMEDICAKE produced results that were "cosmetically and therapeutically good"[1]—and no adverse effects were experienced. Its convenience and elegance achieve continued cooperation from grateful patients.

Applied with a damp sponge, COSMEDICAKE goes on the skin smoothly and uniformly as a reconstituted fast-drying lotion with no separation, no precipitation or uneven concentration. May be used morning and night...helps the patient gain confidence by improving her appearance while lesions are healing.

COSMEDICAKE contains hexachlorophene, benzalkonium chloride, salicylic acid, and colloidal sulfur in a smooth, greaseless, pharmaceutically elegant base.

4 skin-matching shades available at all pharmacies.

1. Berger, R. A.: Clinical Medicine, Sept. 1961.

also available:

COSMEDICAKE for Dry Skin—effective topical medication specially formulated for patients with dry skin...provides lipids for softening and moisturizing actions.

for samples
and complete literature write:

KAY PREPARATIONS COMPANY, INC.
345 West 58 St., New York, N.Y. 10019





Smooths out emotional peaks and valleys

'Meprospan'-400 brand of meprobamate contains 400 mg. in sustained-release form. One capsule smooths out the anxious patient's emotional peaks and valleys for 10 to 12 hours — and provides these other advantages:

1. **Especially suitable for maintenance therapy.** Patients whose anxiety has diminished to a mild or moderate level still require a certain amount of tranquilization throughout the day. Sustained-release action is ideally suited to this type of patient.
2. **Simpler dosage schedule.** Since one capsule of 'Meprospan'-400 (meprobamate, sustained release) acts 10 to 12 hours, the patient enjoys a much simpler dosage schedule than with tablets — and is less likely to forget to take the medicine.

Side Effects: Rarely, skin reactions. May increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence in patients with history of drug or alcohol addiction.

Available: *'Meprospan'-400* (meprobamate, sustained release) contains meprobamate 400 mg. *'Meprospan'-200* (meprobamate, sustained release) contains meprobamate 200 mg. Both potencies in bottles of 30. **Usual dosage:** One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Meprospan®-400
meprobamate 400 mg.
sustained release

WALLACE LABORATORIES / *Cranbury, N.J.*

CME-9133

effective in sudden-onset hearing loss, tinnitus, vertigo... due to labyrinthine ischemia



arlidin®

brand of **nylidrin HCl**

"Significant hearing improvement" occurred with Arlidin (nylidrin HCl) therapy in 32 of 75 patients with recent-onset hearing impairment due to labyrinthine artery ischemia.

Rubin, W. and Anderson, J. R.: Angiology 9:256, 1958.

Vascular insufficiency of the labyrinth is an important etiologic factor in sudden perceptive deafness... "vasodilators [Arlidin] are of considerable value."

Wilmot, T. J. and Seymour, J. C.: Lancet 1:1098, 1960.

Clinical benefit was obtained in approximately 50% of cases of recent-onset hearing loss treated with adequate vasodilator and other supportive therapy.

Sheehy, J. L.: Laryngoscope 70:885, 1960.

Arlidin (nylidrin HCl) "appears to be one of the most satisfactory [vasodilators], having the advantages of minimal side effects, being well tolerated and possessing a sustained action" in improving circulation of the inner ear.

Seymour, J. C.: J. Laryngology & Otology 74:133, 1960.

Early cases of sudden perceptive deafness should be treated by immediate stellate block "supplemented by the most effective vasodilator drug [Arlidin]... energetic measures to retain blood supply to the inner ear are imperative."

Wilmot, T. J.: J. Laryngology & Otology 73:466, 1959.

SUMMARY: Indicated whenever an increase in blood supply is desirable in circulatory insufficiencies of the extremities, brain, eye and ear. Use with caution in the presence of a recent myocardial lesion, severe angina pectoris and thyrotoxicosis. Contraindicated in acute myocardial infarction.

Arlidin (nylidrin HCl) is available in 6 mg. scored tablets, and 5 mg. per cc. parenteral solution.
Protected by U.S. Patent Numbers: 2,661,372 and 2,661,373.

u.s. vitamin & pharmaceutical corporation . Arlington-Funk Labs., div. • 800 Second Ave., New York, N.Y. 10017



The new specialist

(concentrates on coughs)

Tussicalm, by concentrating solely on cough relief, permits therapeutic and dosage flexibility in treating individual patients, since other symptoms may vary in type, frequency, onset and duration. Mixtures with multi-therapeutic effects may be unnecessary, increase danger of side effects, and result in "inadequate concentrations of effective ingredients...."[1]

With Tussicalm, patients receive concentrated 2-way action.

Noscapine—safe, effective cough suppressant.[2,3] Antitussive potency equal to codeine.[1,4-7] No addiction liability.[1,6,7] Wide margin of safety.[6-8] No opiate-like effects, such as constipation, respiratory depression or blood pressure changes.[5]

Glyceryl Guaiacolate—safe, superior expectorant. Greatly increases and thins bronchial secretions.[9] Facilitates elimination of sputum and soothes irritated bronchial mucosa.[10] Virtually no adverse effects.[9]

Tussicalm, being essentially free of side effects, is available to the whole family without prescription.

ROUSSEL CORPORATION, 155 E. 44 ST., N.Y. 17, N.Y.

ROUSSEL

Each teaspoonful (5 cc.) contains in a delightfully different tasting syrup: Noscapine 10 mg., Glyceryl Guaiacolate 90 mg., Citric Acid Anhydrous 75 mg., and Sodium Benzoate 5 mg. DOSAGE: *Adults:* 2 teaspoonfuls three or four times daily. *Children* (6 to 12): 1 teaspoonful three or four times daily. *Children* (4 to 6): ½ to 1 teaspoonful three or four times daily. SUPPLIED: 4-oz. bottles.

REFERENCES: (1) Bickerman, H. A.: M. Clin. N. America 45:805, 1961. (2) Bickerman, H. A., & Barach, A. L.: Am. J. M. Sc. 228:156, 1954. (3) Segal, M. S.; Goldstein, M. M., & Attinger, E. O.: Dis. Chest 32:305, 1957. (4) Bickerman, H. A. ; German, E.; Cohen, B. M., & Itkin, S. E.: Am. J. M. Sc. 234:191, 1957. (5) New and Nonofficial Drugs, Evaluation by A.M.A. Council on Drugs, Philadelphia, J. B. Lippincott Company, 1962, p. 453. (6) Bickerman, H. A., *in* Modell, W., ed.: Drugs of Choice 1962-1963, St. Louis, The C. V. Mosby Company, 1962, p. 469. (7) Bickerman, H. A.: Clin. Pharmacol. & Therap. 3:353 (May-June) 1962. (8) Winter, C. A., & Flataker, L.: Toxicol. & Appl. Pharmacol. 3:96, 1961. (9) Bickerman, H. A., *In* Modell, W.: *op. cit.*: 474. (10) *Ibid.*: 472.

0163

"Doctor... I'm so tired all the time"



Lethargic patients respond to Ritalin

(methylphenidate hydrochloride)

When lethargy is a medical problem—in convalescence, chronic fatigue, mild depression, menopause, oversedation, and senility, for example—the gentle stimulant action of Ritalin (methylphenidate hydrochloride) restores normal physical and mental activity.

In his report, Siegler[1] states: "In mild depression or in clinical exhaustion syndromes, a marginal sympathomimetic drug like methylphenidate seems to be the drug of choice for initiating therapy. It does not have the toxic effects found with the amphetamines or with the hydrazines or other antidepressants."

Other significant comments on the clinical safety of Ritalin (methylphenidate hydrochloride): "At no time was there evidence of serious toxic reactions [in a study of 185 patients]. The drug did not produce alteration in blood forming factors, kidney and liver function."[2]

"No significant toxic effects have resulted after the continuous administration of methylphenidate for more than 3 years."[3]

INDICATIONS: Chronic fatigue.

CONTRAINDICATIONS: Marked anxiety, tension, and agitation.

CAUTION: Should not be used to increase mental or physical capacities beyond normal limits. Use cautiously with epinephrine or levarterenol.

SIDE EFFECTS: Nervousness, insomnia, anorexia, nausea, dizziness, palpitations, headache, drowsiness.

DOSAGE: 10 to 20 mg. b.i.d. or t.i.d.

SUPPLIED: *Tablets*, 5 mg. (pale yellow), 10 mg. (pale blue) and 20 mg. (pale orange).

REFERENCES: 1. Siegler, P. E., in Nodine, J. H., and Moyer, J. H. (Editors): *Psychosomatic Medicine*, The First Hahnemann Symposium, Lea & Febiger, Philadelphia, 1962, p. 582. 2. Lapolla, A.: Western Med. *2*:383 (Sept.) 1961. 3. Yoss, R. E., and Daly, D. D.: Pediatrics 25:1025 (June) 1960.

2/3098MB

C I B A SUMMIT, N. J.

Ritalin® hydrochloride (methylphenidate hydrochloride CIBA)

cut Rx writing by 2/3 in colds, flu or grippe

NAME _____

ADDRESS _____

℞

No need to write three separate prescriptions for antitussive, decongestant and analgesic relief of common cold, flu or grippe symptoms when it is therapeutically correct... economically sound... to specify

ANTITUSSIVE/DECONGESTANT/ANALGESIC 'EMPRAZIL-C'® TABLETS

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Phenacetin	150 mg.
Aspirin	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming

'Emprazil-C' Tablets are available on prescription only.

Dosage: Adults and children over 12 years—1 or 2 tablets—3 times daily as required. Children 6 to 12 years—1 tablet—3 times daily as required. **Caution:** While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed. **Supplied:** Bottles of 100 tablets.

Also available without codeine as 'EMPRAZIL'® TABLETS

Complete literature available on request from Professional Services Dept. PML.



BURROUGHS WELLCOME & CO (U.S.A.) INC.

Tuckahoe, N. Y.



STARTING TOMORROW MORNING 

this capsule can help one of your overweight patients do without her favorite (fattening) foods at meals—and during all the hours in between.

Dexamyl® Spansule®

Trademark — brand of sustained release capsules

Each No. 2 capsule contains 15 mg. of Dexedrine® (brand of dextro amphetamine sulfate) and 1½ gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each No. 1 capsule contains 10 mg. of Dexedrine (brand of dextro amphetamine sulfate) and 1 gr. of amobarbital [Warning, may be habit forming].

The active ingredients of the 'Spansule' capsule are so prepared that a therapeutic dose is released promptly and the remaining medication, released gradually and without interruption, sustains the effect for 10 to 12 hours.

INDICATIONS: (1) For control of appetite in overweight; (2) for mood elevation in depressive states.

USUAL DOSAGE: One 'Dexamyl' *Spansule* capsule taken in the morning.

SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

CAUTIONS: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these rare instances withdrawal of medication is recommended. It is generally recognized that in pregnant patients all medications should be used cautiously, especially in the first trimester.

SUPPLIED: Bottles of 50 capsules.

Smith Kline & French Laboratories SK&F *Prescribing information Jan. 1963*



Notable increase in vigor, strength and sense of well-being

NSTROL (stanozolol-Winthrop), a heterocyclic steroid, combines
ent anabolic effects with outstanding tolerance, stimulates appe-
e and promotes weight gain... restores a positive metabolic balance.
counteracts the catabolic effects of concomitant corticosteroid or
TH therapy. WINSTROL (stanozolol-Winthrop) rebuilds body tissue
ile it builds strength, confidence and a sense of well-being in con-
ions associated with excess protein breakdown, insufficient protein
ake and inadequate nitrogen and mineral retention.

le Effects and Precautions: Prolonged administration can produce
ld hirsutism, acne or voice change. In an occasional patient, edema
s been observed and in young women the menstrual periods have
en milder and shorter. These side effects are reversible, and pa-
nts receiving prolonged treatment should be examined and ques-
tioned periodically so that, should side effects appear, the dosag
may be reduced or administration of the drug discontinued for a tim
In patients with impaired cardiac and renal function, there is the pos
sibility of sodium and water retention. Liver function tests may revea
an increase in bromsulphalein retention, particularly in elderly pa
tients. In such cases, therapy should be discontinued. Although it ha
been used in patients with cancer of the prostate, its mild androgeni
activity is considered by some investigators to be a contraindicatior

Dosage: Usual adult dose, 1 tablet t.i.d. before or with meals; youn
women, 1 tablet b.i.d.; children (school age): up to 1 tablet t.i.d.; chi
dren (pre-school age): ½ tablet b.i.d. Available as scored tablets
2 mg. in bottles of 100. For best results, administer with a high protei
diet.

WINTHROP LABORATORIES, NEW YORK 18, N.

larked improvement in appetite / Measurable weight gain Winthrop

The one tranquilizer that

BELONGS IN EVERY PRACTICE

it's versatile: The years have proved that 'Miltown' (meprobamate) is the one tranquilizer that is helpful in almost every aspect of daily practice. Virtually any of your patients, regardless of age, can be given the drug with confidence, either as a primary treatment or as an adjunct to other therapy.

Outstanding record of safety: Over eight years of clinical use among millions of patients throughout the world — plus more than 1500 published reports covering the use of the drug in almost every field of medicine — support your prescriptions for 'Miltown' (meprobamate). This is why it *"belongs in every practice."*

dependable: 'Miltown' (meprobamate) is an established drug. There are no surprises in store for you or your patient. You can depend on it to help your patients through periods of emotional distress — and to help maintain their emotional stability.

easy to use: Because 'Miltown' (meprobamate) is compatible with almost any other kind of drug therapy, you'll find it fits in easily with any program of treatment you are now using. It will not, therefore, complicate treatment of patients seen in clinical practice.

BRIEF SUMMARY: *Indications:* Anxiety and tension states, and all conditions in which anxiety and tension are symptoms. *Side Effects:* Slight drowsiness may occur and, rarely, allergic or idiosyncratic reactions, generally developing after 1-4 doses of the drug. *Contraindications:* Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. *Precautions:* Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities, to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available to physicians on request.*

USUAL ADULT DOSAGE: 1 or 2 400 mg. tablets t.i.d.

SUPPLIED: 400 mg. scored tablets, 200 mg. coated tablets.

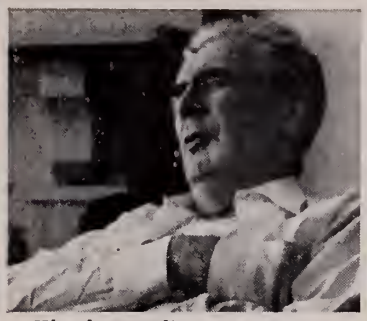
CM-9694



The insomniac



The tense, nervous patient



The heart-disease patient



The surgical patient



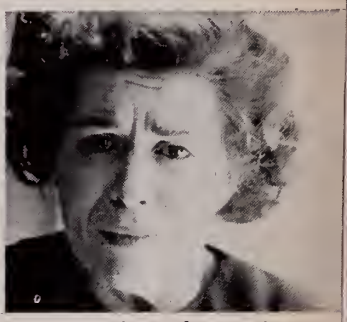
e girl with dermatosis



Tension headache



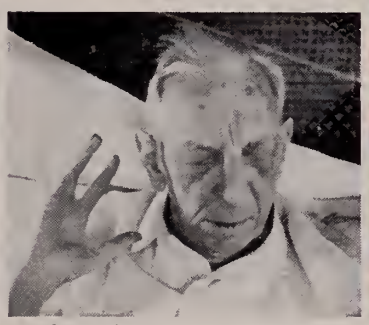
The woman in menopause



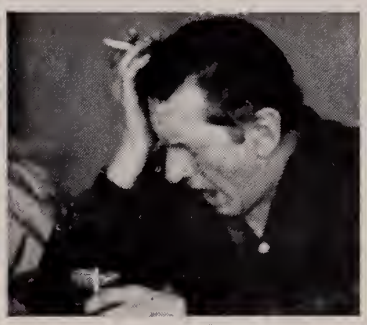
Anxious depression



remenstrual tension



The agitated senile patient



The alcoholic



The problem child

the original brand of
meprobamate

Miltown®



The G.I. patient

WALLACE LABORATORIES
Cranbury, N.J.

YOU CAN HAVE A

TAX EXEMPT INCOME

1—The interest received from Municipal Bonds is fully exempt from all present Federal Income Taxes, and is not reported on your tax return.

2—The safety factor of Municipal Bonds is second only to securities of the U. S. Government.

3—We presently have a special offering of general obligation Municipal Bonds, which will yield a 3.40 - 3.50% TAX EXEMPT return.

We would like to send you our chart, which illustrates the advantages of tax exempt income—it will show how much, depending on your income bracket, any given tax exempt yield will mean to you in taxable equivalent income.

Our booklet "The Story Behind Municipal Bonds" is also available at no charge upon request. After reading it, you will have a better understanding of the safeguards surrounding such bonds.

JOHN J. RYAN & CO.

STATE AND MUNICIPAL BONDS

790 BROAD STREET NEWARK, N. J.

Phone MI 3-8350

Tear off

PLEASE FORWARD TO ME

☐ Tax free vs. Taxable Bond chart.

☐ Booklet—"The Story Behind Municipal Bonds".

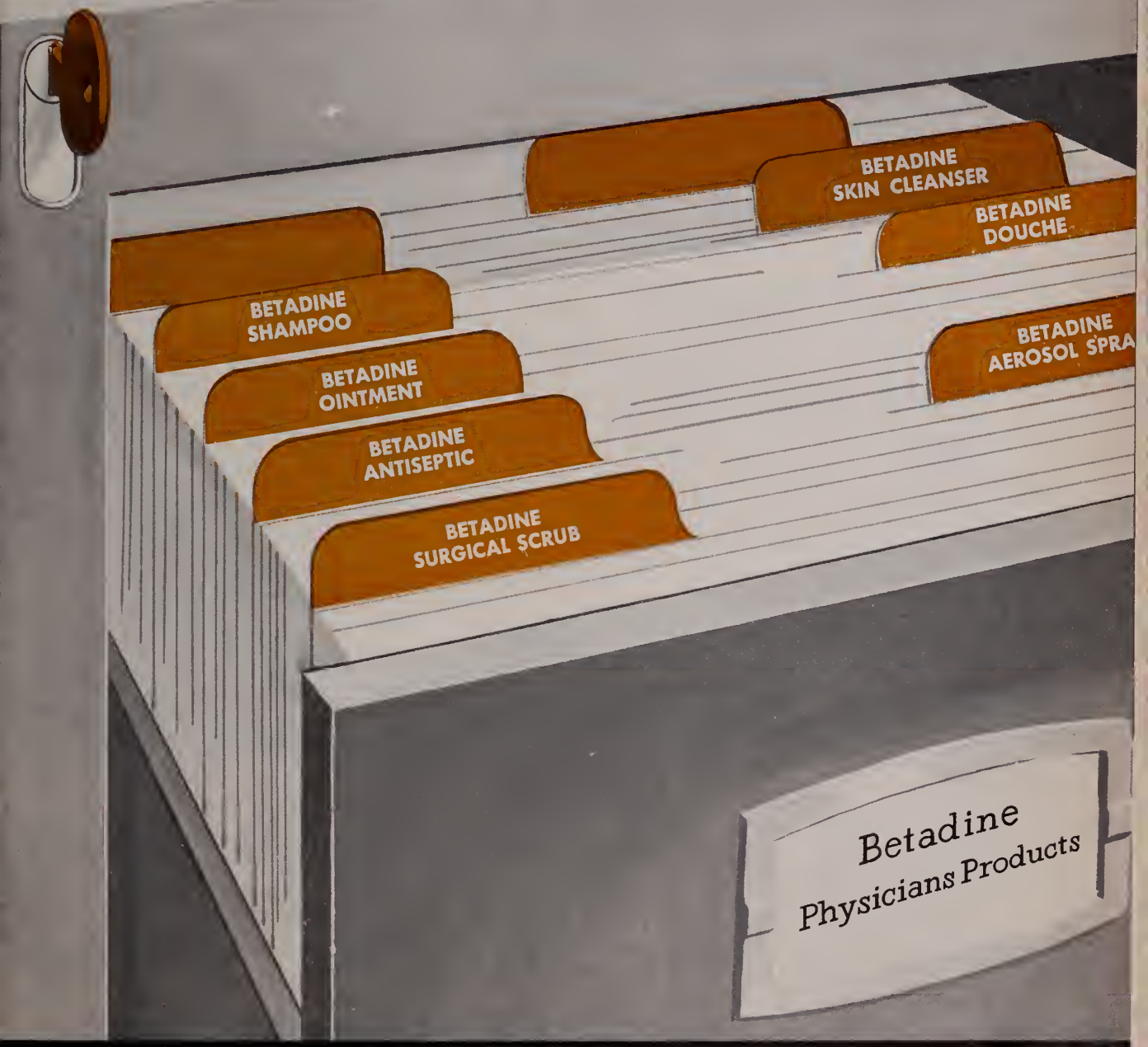
☐ Please send me your current offering sheet.

Betadine®
Povidone-Iodine
Products
unlock a wide range of usefulness

Betadine Products, in all seven dosage forms, contain povidone-iodine, a complex of polyvinylpyrrolidone and iodine, providing all the germicidal properties of elemental iodine . . . yet Betadine (povidone-iodine) is nonirritating, nonsensitizing, and nontoxic to skin or mucosa.

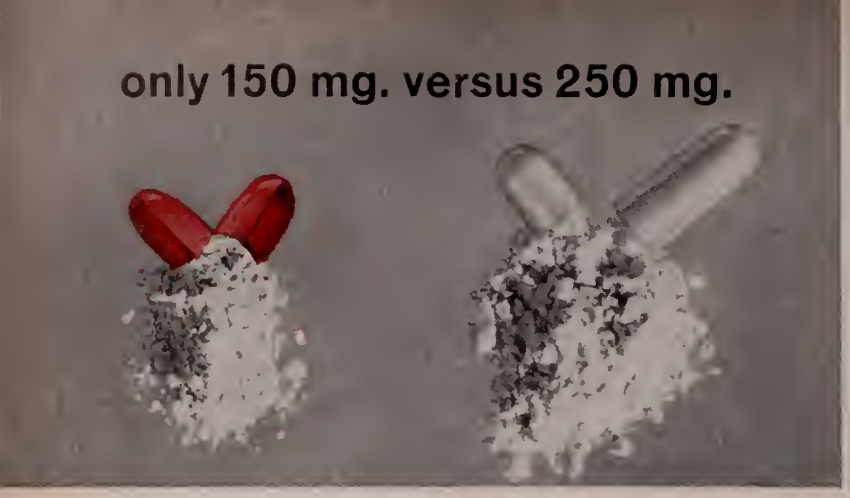
Betadine Products are effective in preventing and treating a variety of infections frequently encountered in the practice of otolaryngology, orthopedics and orthopedic surgery, obstetrics and gynecology, oral surgery, pediatrics, surgery and dermatology.

The clinical results reported under various conditions of use make Betadine (povidone-iodine) preparations valuable adjuncts both in the hospital and in private practice. Literature available upon request.

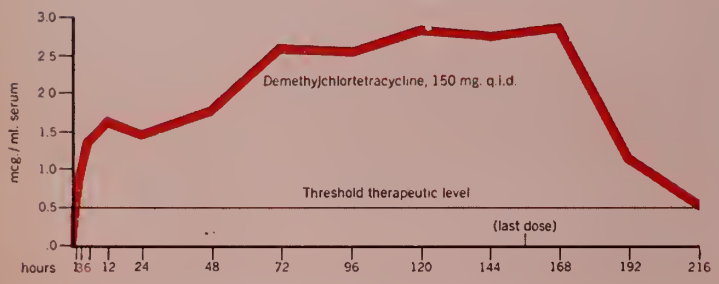


PHYSICIANS PRODUCTS CO., INC.
PETERSBURG, VIRGINIA

only 150 mg. versus 250 mg.

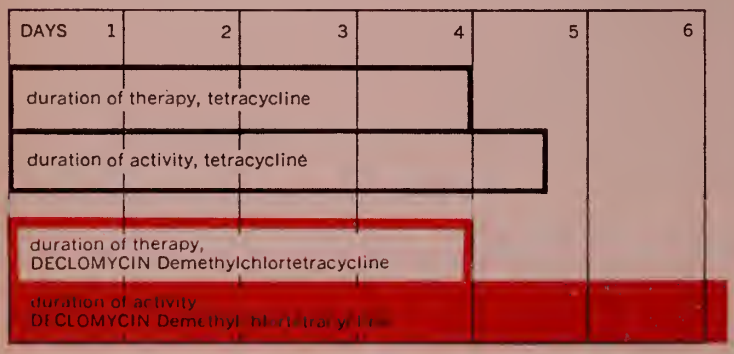


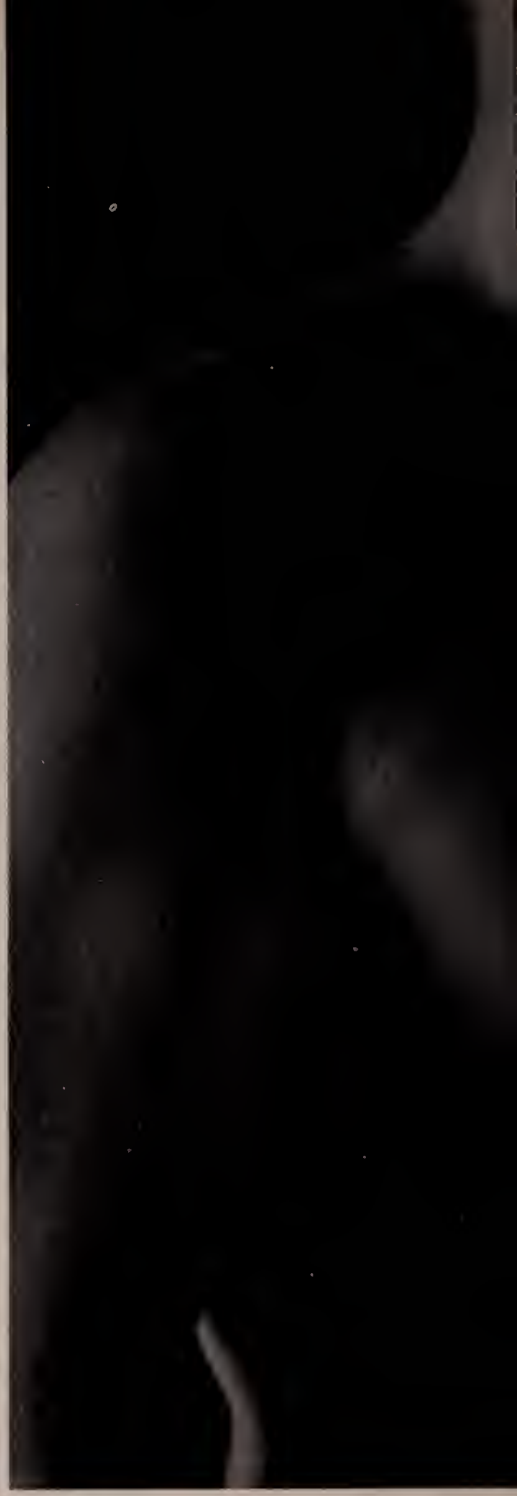
higher activity levels than other tetracyclines



From Sweeney, W. M., Dornbush, A. C., and Hardy, S. M. *Amer. J. Med. Sci.* 243,296 (Mar.) 1962.

1-2 days' "extra" protection





gives you an "extra dimension" of antibiotic control



DECLOMYCIN®

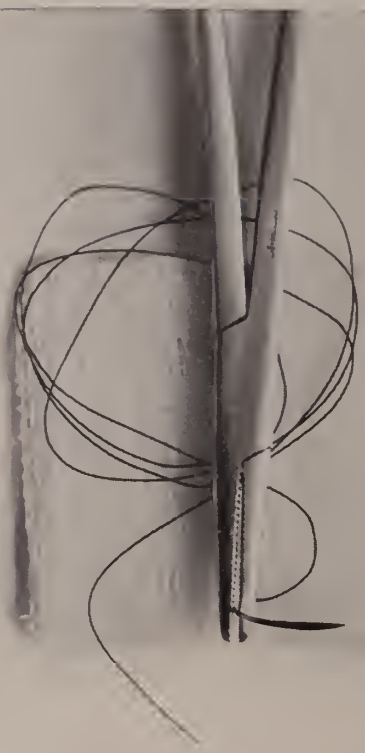
DEMETHYLCHLORTETRACYCLINE HCl

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. *Side Effects* typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. *Capsules,* 150 mg. and 75 mg. of demethylchlortetracyline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 b.i.d.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

7150-3

Lederle



In trauma,
whether it's
sutures, plaster,
splint or sling...

remember
'Empirin'
Compound
to relieve pain



Also: 'Empirin'® Compound with Codeine Phosphate*
gr. ⅛—No. 1/gr. ¼—No. 2/gr. ½—No. 3/gr. 1—No. 4
*Warning—may be habit forming

blood, milk and Maalox®

(magnesium-aluminum hydroxide gel)

Practically standard treatment, now, for bleeding ulcer. Why is Maalox included? Antacid therapy *must* continue long after the wound has healed, and patients started on Maalox tend to stay on Maalox. It tastes good; it's effective and will not cause constipation—three important reasons for Maalox over the long haul. Some physicians, we are told, order Maalox routinely for hospital patients on drugs which could irritate. They feel it reduces the likelihood of gastric discomfort. Supplied: Suspension; Tablets No. 1; Tablets No. 2. (Each Maalox No. 1 Tablet is equivalent to 1 teaspoonful and each Maalox No. 2 Tablet is equivalent to 2 teaspoonfuls of Suspension.)



ROHER

WILLIAM H. RORER, INC., FORT WASHINGTON, PA.

to bring her back into balance after menstrual irregularity



an orally active progestogen-estrogen combination

Duosterone®

Ethisterone . . . 10.00 mg. Ethinyl estradiol . . . 0.01 mg. per tablet

Supplementing and supporting ovarian function, DUOSTERONE can help release your patients from the anxiety, discomfort and inconvenience of functional amenorrhea, dysmenorrhea, and dysfunctional uterine bleeding.

Periodic progestational treatment with DUOSTERONE aims at restoring the normal hormonal pattern of the secretory phase of the menstrual cycle, providing an orally active progestogen with an estrogen to prime the endometrium for adequate progestational response.

Dosage: Functional amenorrhea, 5 tablets daily for 5 days. Dysmenorrhea, 1 to 2 tablets daily during the second half of the menstrual cycle, except for the final two days. Dysfunctional uterine bleeding, 5 to 7 tablets daily for 5 days; in mild cases, reduce dose 1 tablet each day.

Side Effects: Ethinyl estradiol may occasionally cause headache, diarrhea, engorgement and tenderness of the breasts, nausea, vomiting, cramping, or skin rash. These side effects usually fade as the patient adjusts to the estrogen.

Cautions and Contraindications: DUOSTERONE is contraindicated in carcinoma of the breast and reproductive organs and should be used with caution in cases of known liver impairment.

Supplied: Bottles of 25 and 100 tablets.

ROUSSEL

Roussel Corporation
155 East 44th Street, New York 17, N.Y.



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain...not the patient").*

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

®WALLACE LABORATORIES / *Cranbury, N.J.*

CSO-9193



Empty capsules are filled by the finest precision machinery available . . . but no machine is perfect. That's why all Lilly Pulvules® (filled capsules) are given the "thirty-minute checkup" to be certain that uniformity is maintained. At least once every thirty minutes ten filled capsules are taken from each machine and carefully weighed on a prescription balance. In addition, the checks are double-checked at least four times each day . . . another of the many stringent controls which assure you that the Lilly products you prescribe provide quality that merits the full measure of your confidence.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

300180

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Total Information and Psychic Injury

The modern doctor's dilemma is this. If he does *not* tell the patient the possible complications, he may be liable for malpractice. If he *does* tell, he may be liable for causing anxiety. The latter threat has been haunting us ever since a New York court held a physician liable for frightening a patient by hinting that a keloid "might become malignant." The patient's subsequent anxiety was held to be the doctor's fault. This has led to a number of suits making similar claims.

Not all of them have been successful. In one case,* a doctor told a patient that her previously arrested pulmonary tuberculosis had become re-activated. This produced terrific anxiety and her lawyer said it was like the cancerphobia case where the physician was held liable. He wanted damages for a tuberculosis phobia. However, the Court directed a verdict for the doctor, saying:

> In the light of the overwhelming evidence that the diagnosis of active tuberculosis disclosed by him to the plaintiff and his administration of effective chemotherapy were medically warranted and constituted no deviation from standard medical practice. The doctor had thus met all the tests of skill and learning, method of treatment and acceptable standards for medical care.
>
> On all the evidence the statement (that the "germs may have reached her intestines") clearly was a requisite medical technique to induce plaintiff, then suffering from stomach pains, to undergo the treatment and indeed, though she may have been badly frightened, plaintiff may be alive today because of the very chemotherapy thus administered to her.

The judge also discussed recent decisions which held that a person may recover damages for emotional injury caused by a negligent act without physical injury or contact. However, he noted that no cases had held a doctor liable for causing fright and psychic injury brought on by a statement *in the course of the diagnosis or treatment.*

The Court noted that the doctor may have been mistaken and, possibly should have awaited added medical proof "but certain it is that it was an understandable error, if not an error of judgment."

*Cited in the May 1, 1963, New York State Journal of Medicine.

Published Monthly Since 1904 — Henry A. Davidson, M.D., Editor
Under the Direction of the Committee on Publication — Theresa E. Goeke, Assistant Editor
George B. Sharbaugh, M.D., Chairman
Place of Printing and Mailing — 116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton, N. J.
Send all communications for publication to P.O. Box 904, Trenton, N. J. 08605—EX 4-3154
Send all communications regarding advertising to Joseph W. Cookson, 370 Morris Ave., Trenton, New Jersey 08611 — EX 3-7196
Each member of the Society is entitled to receive a copy of The Journal every month
Whole Number of Issues 711

Vol. 60, No. 11 — NOVEMBER, 1963 — 50 Cents - $5.00 per year

Of particular importance and interest is this observation of the judge:

> Had this defendant failed fully to alert plaintiff he could have been subjected to censure and sult. Thus, on the plaintiff's reasoning, *there is jeopardy both for making the disclosure and for withholding it.* Were doctors to be made conscious of the possibility of suit for honestly explaining their diagnosis to patients for purpose of swift cure they would, with so hazardous a cloud over them, tend to avoid doing so. What sort of medicine would we then achieve? The practice of medicine would then become a secretive practice with doctors uncommunicative to patients, delaying therapy and withholding information for fear that frightened patients might turn upon them. Indeed, professionals in other fields would also find advice to clients most hazardous if fright were caused therapy (sic.) thereby. Think of the plight of a lawyer, sued by a frightened cardiac client when informed of the poor prospects of a lawsuit or of the size of the proposed fee which could be exceeded by the client's recovery against the lawyer for fright. In the interest of public health and safety a doctor who stands in a special relationship to his patient, even if his diagnosis be not fully verified, must be free to inform his patient of the presence of disease if he needs to alert her to it or to induce her to embark upon safe and healing therapy.

The Court concluded by stating, in part, that:

> It therefore seems to me that a psychic injury suit, based upon fright from medical advice by a diagnosing doctor, should be confined to gross negligence and is not warranted if the information is well founded, not capricious and does not induce harmful therapy.

Doctors, Politics, and Government

More than 300 physicians have helped shape the destiny of the country as members of the U. S. House of Representatives and Senate. At least 13 also were state or territorial governors. Three states selected physicians as their first governors. Now is the time when many more qualified medical men should step forward and give of their talents in the political arena in *every county* in the United States. This would give to all the people a potent force for the maintenance of freedom of thought as well as for good responsible government.

The doctor's freedom to practice as he chooses may soon be at stake. He cannot sit back and let others carry on his battles. Each physician who actively participates in civic and community affairs is a force that commands respect. This requires the physician's active participation in the political arena. It can demonstrate his varied talents toward good government. His academic background and training and his individualism make him a force and one to be reckoned with.

Time is past when doctors of medicine were told to stay away from politics; that the doctor must be aloof from the machinations of government because he must take sides—for or against—that this would hurt him. Any physician worth his salt has training and experiences that demand the use of his energies for what is good for all people and for good, clean, and honest government. This country was built by those who were self-reliant and not by men and women who relied on someone else.

It is the civic responsibility of all physicians to his fellow Americans to "get out and stay out of our ivory towers."[1] He must not be afraid to stand up and speak out on issues involving the community, state, and nation. In so doing, he may lose some patients and also some income; but he will gain as many as he will lose as long as he is sincere, conscientious, and reasonable.

Former Representative Walter H. Judd, M.D. has given a lucid statement as to why doctors should pay attention to public affairs. Dr. Judd has said:

> "First, we have to do it to insure the conditions which will enable us to practice good medicine with success and justification for ourselves. Second, we have to pay some attention to public affairs in order to influence and improve conditions which adversely affect our patients. There is a third reason: to influence your future and that of your children as citizens, because before anyone is a doctor or clergyman or businessman (and I would add a lawyer), he is a citizen of this Republic."

J. R. Karel, M.D.*
Hillside, N. J.

*Dr. Karel is chairman of the Committee on Disaster Medical Care of MSNJ and is Deputy and Medical Coordinator of Union County Civil Defense and Disaster Control.

1. Alford, Dale in Memphis and Mid-south Medical Journal, 4:191 (1962).

Harvey E. Nussbaum, M.D

Newark

Chronic Fatigue

In a carefully controlled study, aspartates were found helpful in 84 per cent of patients with chronic fatigue: placebos had helped only 26 per cent.

The problem of fatigue confronts all physicians at some time. It transcends all specialties. Under the stress of prolonged physical activity, fatigue occurs as a normal manifestation. It is the physiologic response of muscle to the accumulation of metabolites, and is not relieved until such substances disappear.

Fatigue without activity is unphysiologic; its causes are many. Allan [1] studied 300 cases at the Lahey Clinic. In all, the primary complaint was weakness or fatigue; a "nervous state of one kind or another" was the cause in 80 per cent, and organic disease in 20 per cent. On the other hand, in a series reviewed by Ffrench,[2] only 25 per cent were attributed to "nervous disorders."

Meticulous physical and laboratory examinations are needed to establish the presence or absence of somatic or functional disorders that may underlie, initiate or contribute to the fatigue. If no organic disease is demonstrable, psychogenic factors should be thought of. The *organically* tired patient is exhausted by the slightest effort; the psychogenically fatigued individual feels tired even from contemplating exercise. Often he is relieved by the very activity that tires the organically ill.

Most morbid conditions have fatigue and exhaustion as concomitants; in some, fatigue may be a primary manifestation. A host of illnesses, from anemia to vitamin deficiency (genuine) including metabolic, endocrine, infectious, neurologic, neoplastic and degenerative diseases may spell fatigue. Then there is a completely unclassifiable group who never seek medical attention but avail themselves of propagandized medication for "tired blood," "sluggish livers" and the like.

Attesting, too, to the economic importance of fatigue is the now firmly established American custom, the coffee break. The caffeine content of the average-sized cup of coffee is 75 to 150 milligrams; that of the leading cola drinks,[3] about one-third that contained in an equal amount of coffee. Caffeine is an excellent and proved agent for the relief of fatigue; but it is not well tolerated by all.

Many other measures have been tried. Table 1 lists only the important ones. Most of the

TABLE 1

CONVENTIONAL MEASURES FOR MANAGEMENT OF FATIGUE

1. More rest
2. Psychotherapy, including advice to "accept tiredness as inescapable," and exhortations to readjust the pattern of living
3. Central nervous system stimulants and euphoriants, including caffeine, amphetamine preparations, the monamine oxidase inhibitors ("psychic energizers"), methylphenidate, pipradols and various psychomimetic substances
4. Vitamin preparations, including thiamin, vitamin B_{12}, B-complex and multivitamin compounds
5. Hematinics, including liver, iron and various proprietary "tonics"
6. Amino acids
7. Sedatives
8. Ataraxics
9. Endocrine substances, including desiccated thyroid, estrogens, androgens and other anabolic agents

available pharmacologic substances possess disturbing side actions that have limited their usefulness; and they are now only of historical interest.

Amino acids have been prescribed since it was first suggested that the end products of the Krebs urea cycle might be associated with fatigue. It was thought that amino acids might favor a desirable deviation in the formulation of such end products. The French neurophysiologists, led by Laborit,[4] have advanced a new concept,[5] supported by animal experiments,[6] and clinical observations in several thousand patients.[7 to 12] These workers showed that exhaustion may be prevented and recuperation after exertion favored by providing a suitable substrate to facilitate ion exchange. A combination of the potassium and magnesium salts of aspartic acid functioned best to increase efficiency of cellular metabolism and consequent restoration of energy.

CLINICAL TRIAL

FORTY-SEVEN ambulatory adult patients were studied by blind and double-blind methods in an urban private practice devoted to internal medicine. All returned regularly for three to 18 weeks after the initial interview in the investigation. Therefore adequate follow-up was carried out in each case. Only 10 of the total series (21 per cent) were men. Thirty-nine (83 per cent) were 40 to 85 years of age. An excessive and constant generalized exhaustion was a prominent complaint in all cases—"terribly tired all the time," "miserable all day long," "no energy or drive any more," "I can hardly get up and going in the morning." There was obvious chronicity in all cases.

DIAGNOSES

SEVENTY-TWO per cent had been under prolonged medical or surgical treatment (or both) for serious acute or chronic illnesses for several months to many years. One case (a severe, undiagnosed neurologic disease with bulbar and spinal cord involvement) ultimately was fatal. One or more complications that probably contributed to the sense of exhaustion were present in every instance. In 28 per cent there was no diagnosable somatic disturbance, but there were obvious manifestations of severe anxiety neurosis or functional disorders (Table 2). All patients had been intensively studied by standard methods.

Medication had been administered for exhaustion *per se*. This included vitamins, sedatives, ataraxics, hormones and various types of stimulants. This had not sufficed. All therapy but that specifically indicated for underlying disease was stopped.

TREATMENT

THE series was divided into three groups:

Group A, 10 patients, received only a placebo, which was continued for two to ten weeks.

TABLE 2.

PRINCIPAL DIAGNOSIS IN 47 CHRONICALLY EXHAUSTED PATIENTS TREATED WITH THE ASPARTATES

Diagnosis	Gorup A No. Pts.	B No. Pts.	C No. Pts.	Total
No somatic disease, mainly anxiety neuroses	4	2	7	13
Essential hypertension	3	3	5	11
Diabetes mellitus	1	2	1	4
Rheumatoid arthritis	1	0	0	1
Osteoarthritis	0	1	2	3
Rheumatic heart disease	0	1	0	1
Arteriosclerotic heart disease	1	1	2	4
Congestive heart disease	0	0	1	1
Hypothyroidism	0	1	0	1
Menopausal syndrome	0	1	0	1
Pyelonephritis	0	1	0	1
Bronchial asthma	0	1	0	1
Grand mal epilepsy	0	0	1	1
Retroperitoneal lymphosarcoma (operated)	0	0	1	1
Pulmonary infarction	0	0	1	1
Porphyria	0	1	0	1
Severe undiagnosed CNS disease†	0	0	1	1
Total	10	15	22	47

TABLE 3.

RESPONSE TO TREATMENT

Group	Patients No.	Treatment Courses No.	Results with Aspartates: Satisfactory	Results with Aspartates: Unsatisfactory	Results with Placebo: Positive	Results with Placebo: Negative
A—placebo only	10	10	0	0	2	8
B—aspartates only	15	15	14	1	0	0
C—cross-over:						
2 courses each (13 aspartates, 13 placebo)	13	26	11	2	4	9
3 courses each (15 aspartates, 12 placebo)	9	27	11	4	3	9
Total	47	78	36	7	9	26

Group B, 15 patients, received only the aspartates,* which were continued two to five weeks. Both were treated under the double blind technic; neither the patient nor the observer knew the composition of the tablets administered.

For group C, 22 patients, the aspartates* were alternated with placebos in a cross-over design. The observer substituted one or the other medication for a definite period; but the patient was not told of the change. Thirteen received two courses, one of each agent, for a total of 26 courses, each of which was continued for two to 14 weeks. Seven took the active drug first; six took the placebo first. Nine patients received three courses each, of two to six weeks' duration, for a total of 27 courses. Six received the aspartates,* then the placebo, then the aspartates. The other three received the placebo first and last, with the aspartates between.

Thus 47 patients received 78 treatment courses (the aspartates in 43; the placebo in 35) (Table 3).

DOSAGE

ALL patients received two tablets twice a day, after meals, morning and evening.

Suitable methods were lacking for determining the intensity of the initial exhaustion and the degree of recuperation. It was necessary, therefore, to grade the patients' reactions as "satisfactory" or "unsatisfactory" on the basis of clinical observation and their voluntary reports. These varied from "I feel better" or "I'm not tired now" to "the tablet did wonders" or "I have not felt so energetic in years." (This was graded as an excellent response.) No effort was made to question them closely because of the desire to avoid leading questions. However, when they volunteered the information that they were engaging in new activities, were now working steadily or even that they were staying up later to watch television, this was recorded and taken into consideration.

Blood pressure, pulse and respiration were determined at each weekly visit.

CLINICAL RESPONSES

THE clinical response to 36 of the courses of aspartate medication (84 per cent) was satisfactory, which is in general agreement[8] with the results[9] of others.[10] The response to seven courses (16 per cent) was unsatisfactory (Table 3). Forty-two per cent of the therapeutic results evoked by the aspartates* were considered excellent.

The placebo elicited a positive response in 9 (26 per cent) of the 35 courses, and a

*That is, the salts of aspartic acid. We used the Wyeth brand, tradenamed Spartase®.

negative result in 26 (74 per cent) (Table 3). In none of the nine cases of placebo response was the improvement definite enough to be graded as excellent. In two courses during the cross-over trials (group C) the placebo was administered for one week immediately after cessation of active medication, which had been continued for two and three weeks, respectively. The positive response in each case could have represented a carry-over of effect from the active agent, which also had produced a therapeutic result. The other seven placebo responders all had severe, long-standing physical problems and exhibited particularly strong neurotic tendencies. All wished for relief of their exhaustion so desperately that they would have been disposed to attribute some benefit, at least for a time, to any "new tablet" administered.

The active agent failed in six patients, who received a total of seven courses: *Group B.* (1) A 40-year old man suffering from porphyria. He reported temporary lessening of weakness in the extremities (probably psychological). A true therapeutic effect would have been unlikely. (No placebo.)

Group C. (2) A 57-year old obese woman with grand mal epilepsy, who was under treatment with anticonvulsants and barbiturates. She received two courses of the active medication, both negative; placebo also negative. Her fatigue probably was drug-induced. (3) A 30-year old obese newspaper editor who works under high pressure and consumes quantities of caffeine-containing beverages. He obtained a greater lift from amphetamine. (Placebo positive.) (4) A 50-year old depressed, neurotic woman with a long history of many complaints for which there was never any relief. She takes a variety of medications, none of which she will give up, and she insists on continuing the aspartates although she claims they do no good. (Placebo negative). (5) A 55-year old severely neurotic man with many health phobias. (Placebo positive.) (6) The 60-year old woman with severe undiagnosed central nervous system disease. No medication was of benefit. She subsequently died of cerebral thrombosis. (Placebo negative.)

There was no unusual alternation in blood pressure, pulse or respiration in any patients during treatment.

SIDE EFFECTS

SLIGHT discomfort occurred in two patients (4 per cent): (1) pruritus developed in an arthritic woman after two weeks of medication. Since she had experienced excellent relief of exhaustion, treatment was interrupted for a few days until the itching ceased, and then was resumed without further incident. (2) Nausea occurred in the fatal case. This could have been related to the underlying condition.

COMMENT

THE proper selection of patients for success in treatment of fatigue is somewhat of a problem. In a random selection, the mixture will preclude uniform performance by any pharmaceutical agent. Since the aspartates* presumably exert a general metabolic action, fatigue consequent to long established illness should respond favorably. In fact, in an interesting rat swim test experiment, Rosen and co-workers [5] found that the animals with greatest natural endurance were helped less by preliminary treatment with the aspartates* than were those of lesser endurance. The present study in human subjects, and that of Shaw and associates,[10] tend to confirm this observation.

The action of the aspartates* in the psychoneuroses and other functional disturbances is less clear, yet the combination seemed to relieve some patients in whom no organic disease could be discovered. In depressed people, one could not expect the aspartates to be effective.

The therapeutic action of the aspartates in most cases required two weeks or more to become manifest. Once an effect was produced, it was frequently described by patients in glowing terms.

SUMMARY

FORTY-SEVEN adult ambulatory patients were treated for chronic fatigue in an urban office practice. Seventy-two per cent had been under prolonged medical or surgical treatment or both for several months to many years. Twenty-eight per cent had no diagnosable somatic disease, but showed evidence of severe anxiety neurosis or functional disorders.

Ten of the subjects received placebos only and 15 received the potassium and magnesium salts of aspartic acid. For 22, the aspartates* were alternated with placebos in a cross-over design. Thirteen received two courses, one of each agent, for a total of 26 courses. Nine received three courses each, for a total of 27 courses. Thus 47 patients received 78 treatment courses (the aspartates in 43, the placebo in 35). Each patient was followed for three to eighteen weeks.

A therapeutic response to the active medication was obtained in 84 per cent; the result was negative in 16 per cent. A placebo response occurred in 26 per cent.

695 Clinton Avenue

BIBLIOGRAPHY

1. Allan, F. N.: New England J. Med., 231:414 (1944).
2. Ffrench, G.: Canadian Medical Association Journal, 82:665 (1960).
3. Queries and Minor Notes: Cola Drinks. J.A.M.A., 156:1376 (1954).
4. Laborit, H.: *Stress and Cellular Function,* Philadelphia 1959, Lippincott, p. 76.
5. Rosen, H., Blumenthal, A. and Agersborg, H.P.K.: Journal of Pharm. Sc., 51:592 (June, 1962).
6. Walkenstein, S. S., *et al.*: J. Phar. Sc., 51:598 (June, 1962).
7. Kruse, C. A.: Northwest Med., 60:597 (1961).
8. Taylor, B. B.: West. Med., 2:535 (1961).
9. Formica, P. E.: Current Therap. Res., 4:98 (March, 1962).
10. Shaw, D. L., Jr., *et al.*: American Journal of the Medical Sciences, 243:758 (June, 1962).
11. Crescente, F. J.: Journal of Abdominal Surgery, 4:73 (May, 1962).
12. Friedlander, H. S.: Current Therapeutic Research, 4:441 (September, 1962).

Keep the Safety Belt On

Use of safety belts increased substantially during 1962, as two important trends developed to testify to their growing acceptance by the motoring public.

At the beginning of 1962, only one state—Wisconsin—required that safety belts be installed on all new cars. By the end of the year, however, ten states had introduced such legislation.

In the private sphere, several national auto fleet operators have ordered their cars equipped with safety belts, and many of these have arranged as well to have safety belts made available to their employees for their personal cars under special distribution programs.

Safety belts contribute to motoring safety for two basic reasons.

1) *You are safer inside the car than if thrown out of it.* A body catapulted out of a car runs greatly increased hazards not only from being smashed directly onto the street or other object, but also from the danger of being hit by oncoming traffic. Furthermore, the car usually acts as protective armor for objects inside it in taking the initial shock of collision with another object. This absorption of the initial shock often marks the difference between life and death, or between minor and serious injury.

2) *You are less likely to be dashed against the interior of your own car.* Without a safety belt to hold you in place, your body acts like any loose object that can fly around inside the car. The safety belt thus reduces the likelihood of smashing yourself against the windshield, or onto the steering column or other protruding objects inside the car.

In the light of these important considerations, the slight annoyance of having to fasten safety belts seems a minor price to pay for the increased safety you get. Don't play Rushin' Roulette with your life or the lives of your passengers. Keep the safety belt on.

* From the Travelers Insurance Company (Hartford, Conn.) book of Accident Data, May 1963.

Peter Braun, M.D.

Trenton

Alvin A. Florin, M.D.

South Orange

Drinking Water and Congestive Heart Failure*

Sodium Concentration of Selected New Jersey Water Supplies

Doctors who recommend restricted sodium intake may not realize how much sodium can enter through ordinary drinking water. Detailed tabulations by geographic distribution are available from the Department of Health.

The treatment of congestive heart failure is a common cardiovascular problem. Fluid retention often complicates the management of cirrhosis, the nephrotic syndrome, and toxemia of pregnancy. The restriction of sodium in the diet has become a cornerstone of medical treatment in edematous states. In these days of new and potent diuretic medications, it is not unusual to find that a case of particularly stubborn heart failure can be attributed to some dietary excess of sodium that was unappreciated by the patient or physician. To the list of possible sources (which already encompasses such items as bicarbonate of soda, aspirin or pickles) we should add drinking water as a potentially important source of sodium ion.

Physicians often consider sodium derived from drinking water to be negligible. While this may be true, the sodium content of potable water is highly variable. In certain parts of the country, a quart of drinking water may provide much more sodium daily than that allowed in a 500 milligram diet. Recent literature[1] includes well-documented examples of sodium from drinking water as a cause of cardiac decompensation. In many areas, sodium in water supplies may be a significant factor in chronic congestive heart failure and other edematous states. However, since the taste of drinking water is often not affected and health is not impaired in normal individuals, the sodium is usually undetected.

For patients on sodium restriction, definite limits for sodium in drinking water have been proposed. The American Heart Association has recommended[2] that patients on moderate sodium restriction, a 1,000 milligram sodium diet, should use water containing no more than 5 milligrams of sodium in each 240 cubic centimeter (8 ounce) glass. Such water would provide 20 milligrams in the usual daily intake of one liter (about a quart).

A survey of municipal water supplies in New Jersey has therefore been initiated. Although overall evaluation of all water supplies

Dr. Braun is Medical Officer, United States Public Health Service, on assignment to New Jersey Department of Health. Dr. Florin is the Coordinator, Heart and Circulatory Disease Program, New Jersey Health Department.

in the state will take over a year, many of the 53 determinations made to date disclose sodium concentrations high enough to make the consideration of drinking water mandatory in planning sodium restricted diets.

Naturally occurring supplies of saline water are associated with underground deposits of salt, and in some areas with the admixture of sea water. As in many other areas of our complex civilization, technology has produced problems which were not fully anticipated. Water softening, which has become popular in many areas where excess calcium and magnesium salts are present, can appreciably raise the sodium content of the water.[5]

Water softeners used in homes as well as in large treatment plants were found, in this survey, to be an additional and unsuspected source of sodium.

WATER PROCUREMENT

WATER samples were obtained from representative taps in the distribution system of each water supply. One-liter samples were taken in the usual fashion for chemical and biologic testing. In addition to the specimens of municipal water obtained in this way, samples were taken to measure the effect of domestic water softening equipment. In four homes using water softeners, one sample was taken before softening, and a second after.

DETERMINATION OF SODIUM

SODIUM concentration was measured at the laboratory of the New Jersey State Health Department in Trenton. Determinations were done on the Coleman "21" Flame Photometer. Standard solutions were included in each run of water specimens. Standard deviation of duplicates was plus or minus 0.2 milligrams per liter.

RESULTS

PRIOR to this study, determinations of sodium concentration had not been a regular part of the laboratory procedure for water samples in New Jersey. Furthermore, since the regular sampling program requires two years to cover the state's over-350 public water supplies, the usual order of sampling was altered.

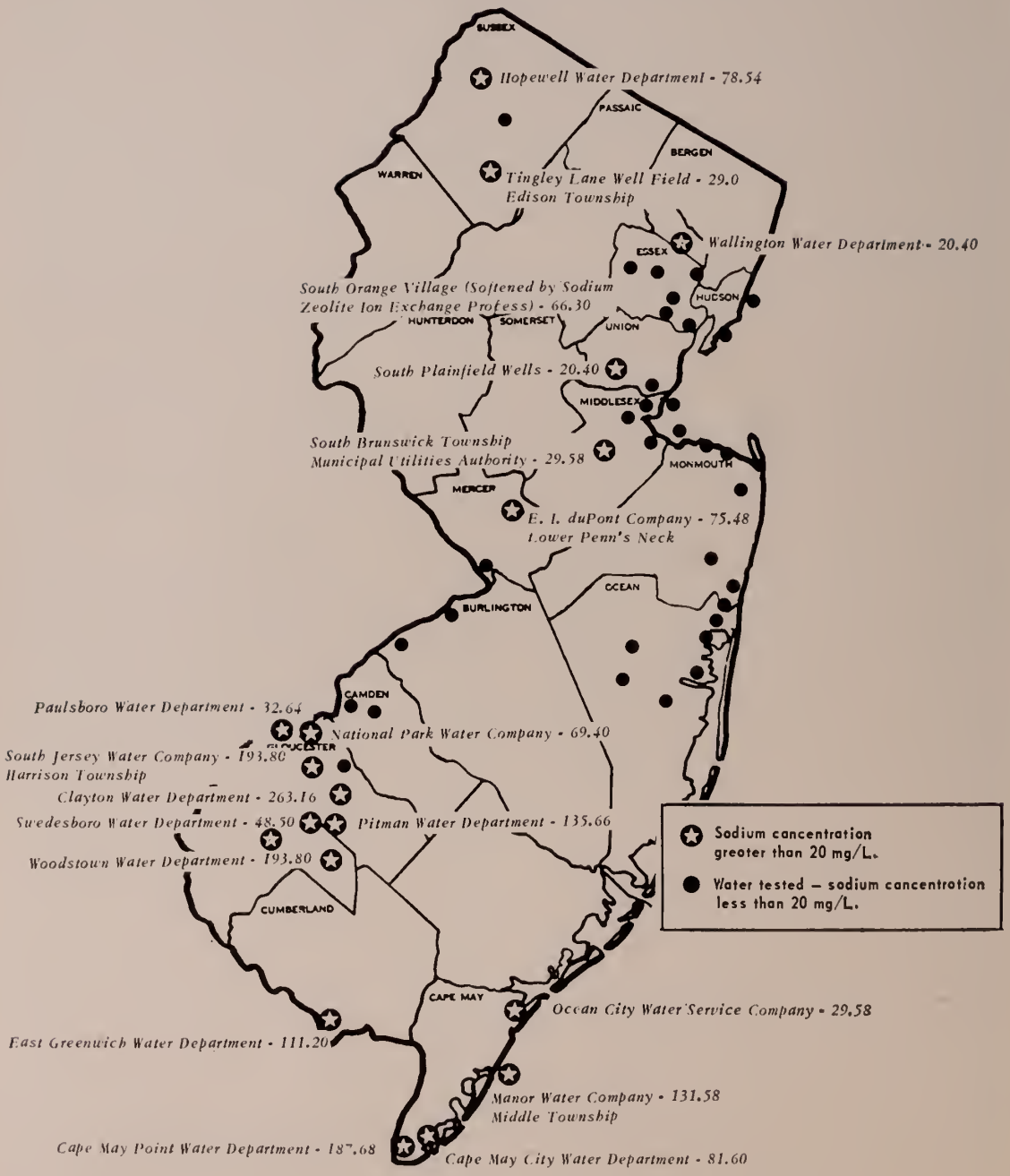
Samples from the ten largest cities in New Jersey were included in this selection. In addition an effort was made to locate areas with the greatest likelihood of having high sodium concentrations. Thus, all water supplies with chloride concentrations known to exceed 30 parts per million and all with total hardness exceeding 200 parts per million were included. This selection was based on the rise of chloride that accompanies contamination of fresh water by salt water influx, and the tendency of water from underground sources to have increased calcium and magnesium.[5] In addition, water was taken from one community known to use large scale softening in the treatment of its municipal water supply. This sampling program provides us with water from the major geographic subdivisions of the State, its largest cities, and certain selected areas thought to have a greater-than-average likelihood of excess sodium concentration.

Results of sodium determinations on water supplies in 53 communities are summarized in tables available on request to the State Health Department.† The sodium concentrations of twenty of these exceed the recommended maximum of 20 milligrams per liter of drinking water. Twelve contain sodium in excess of 60 milligrams per liter, or three times the maximum desirable for moderate sodium restriction. Several supplies high in sodium concentration lie in the southern portion of New Jersey. A high level was also found in one metropolitan community in the northeastern portion of the State. This high concentration was associated with a community water softening plant. Thus, we can identify localities where potable water sodium is elevated.

An additional problem for the physician is the fact that the water a patient drinks at home, in a restaurant or at his place of work may have a much higher sodium concentration than that of the public water supply. Water

†Table will be sent to reader on request directed to Division of Chronic Illness Control, Box 1540, Trenton 25, N. J.

LOCATION OF WATER SUPPLIES TESTED



EFFECT OF HOME WATER SOFTENER ON SODIUM AND TOTAL HARDNESS
FOUR NEW JERSEY HOMES SAMPLED IN 1963

Case	Sodium (miligrams per liter)		Hardness (milligrams per liter) calcium carbonate)		Remarks
	Before Treatment	After Treatment	Before Treatment	After Treatment	
			(milligrams per liter)		
1	9.2	150	280	22	Ion exchange unit renewed within 2 weeks.
2	6.1	100	218	26	Ion exchange unit renewed within 2 weeks.
3	10.2	84	170	12	New ion exchange unit.
4	15.5	16.1	90	88	Not renewed since 1961.

softening equipment, based on ion exchange resins, is available for these private water supplies. All commercially available individual processes share the common potentiality of substituting sodium ion in chemically equivalent amounts for the calcium and other anions [6] which they are intended to remove. In the usual system each two sodium ions replace each ion of calcium or magnesium removed.

We have prepared a table† showing the effect of water softening by the ion exchange process in selected homes within New Jersey. In each case the hardness of the water is indicated as milligrams of calcium carbonate per liter. This information is provided because the amount of sodium released is limited by the quantity of available anions it can replace. Other variables, such as the rate of water flow through the resins, and recharging of the resin to replace accumulated calcium and magneisum, are also of importance. The availability of anions, however, sets the upper limit to the attainable sodium concentration. Sodium concentration as high as 150 milliequivalents per liter, was achieved in one softener-equipped home. This is over seven times the maximum recommended by the American Heart Association for moderate sodium restricted diets. The possibility of obtaining even higher sodium concentration through water softening exists where total hardness is greater than it was in this case, as in some private wells and water supplies.

Water softening in the home is more prevalent in areas where concentrations of calcium and magnesium ion are great enough to affect the use of water for washing, or where hardness begins to exceed approximately 200 parts per million. One of our tables† lists the hardness of selected water supplies in New Jersey, including all supplies with hardness known to be over 180 parts per million. In these areas, water softening may be of the greatest significance.

Where the hardness is less, sodium concentrations cannot be driven as high as a result of softening. Failure to renew or regenerate the exchanger unit by immersing it in saline solution will result in ineffective exchange.

COMMENT

DRINKING water can be a significant source of sodium intake for persons with congestive heart failure and other diseases associated with fluid retention. Concentrations as high as 260 milligrams of sodium per liter exist in New Jersey public water supplies. Commercial and domestic water softening squipment (the presence of which in the patient's home is often unknown to the physician) can raise sodium concentrations to levels far beyond those desirable for such patients.

It has been recommended that persons on moderate sodium restricted diets, one gram per day, should drink water containing no more than five milligrams per glass, or 20 milligrams per liter. We have tabulations† showing the amount of sodium that can be consumed in one to four glasses at various concentrations which are known to exist in

New Jersey. Thus, for example, a man who drinks four glasses of water with a concentration of 50 milligrams per glass ingests approximately 200 milligrams of sodium. Thus, he would get 20 per cent of his daily one gram allotment of sodium by this route alone, or 40 per cent of a 500 milligram sodium diet daily allowance. Water used in soup, coffee, tea, beverages bottled with water from the same supply, or juices mixed with tap water will raise his intake of sodium even higher.

It is important to emphasize the role of water softeners as an occult source of sodium. It is not enough to know the concentration of the public water supplies where a patient lives. An ion exchange water softener in his own home may be adding large amounts of sodium to his diet. Thus, it is essential to find out whether a home water softener is used, particularly in cases of congestive heart failure which have been difficult to manage. *This item should be a part of the history in any patient with severe or recurrent congestive heart failure.* In all such cases (whether a water softener is known to be present or not) a logical step is to sample water from the patient's own home. The sodium can be easily measured in most hospital laboratories, or by any commercial laboratory equipped with a suitable Flame Photometer.

Although the study of water supplies in New Jersey is not yet complete, some generalizations can provisionally be made. The highest concentrations found thus far are in the southern portion of the State, with the exception of one community in the metropolitan northeastern portion where the public water supply is processed in a community water softening plant. As far as is known, this is the only instance of large scale municipal water softening in the State.

In general, the highest concentrations here in New Jersey are well below those of some western states. Nevertheless, for individuals with decompensated water balance, even the moderate amounts of sodium in certain New Jersey water supplies may be of critical importance. Sodium from this source has contributed to difficulty in treating some patients who have failed to respond to the usual methods.

REMEDIAL ACTION

THE steps that can be taken once an unusual concentration is found to be present in the drinking water will vary with circumstances. Where a home water softening device is involved, it will be easy for the patient to substitute water from a more suitable source. With a public water supply, other steps are needed. Water from neighboring communities known to have normal amounts may be used. Careful attention must be given to the choice of bottled beverages. Several excellent tables are available[7] which list the content of sodium and other constituents of common beverages.[8] It should be noted that variations from one bottling plant to another are not reflected in these tables. Many natural fruit juices contain low concentrations of sodium. When juices are made in the home from frozen or liquid concentrations with tap water, however, attention must be paid to the water supply being used as a diluent. For the severe management problem, distilled water may be the most efficient and simplest substitute. To improve its taste, it may be carbonated in the home with carbon dioxide capsules or served in tea, coffee, and fruit juice.

SUMMARY AND CONCLUSIONS

1. A partial survey of public water supplies in New Jersey has revealed that several contain concentrations of sodium which are excessive for patients on sodium restricted diets. Of 53 selected water supplies tested, 20 yielded sodium concentrations greater than that recommended for persons on moderate sodium restricted diets. Of these, twelve showed a concentration over three times this recommended value. Thus, significant quantities of sodium can be ingested with customary water intake by persons with congestive heart failure. Several illustrations show the extent

by which water softening equipment can raise the sodium content of treated water to levels undesirable in relation to sodium restriction.

2. A complete survey of public water supplies in New Jersey with respect to sodium concentration is in progress. The pattern of findings now available is discussed, as are the implications of the study in the management of congestive heart failure and other disease states.

3. We have stressed the importance of considering drinking water as a source of significant quantities of sodium, to the extent that testing water from the patient's own home may be of great clinical importance in treating congestive heart failure.

The State Department of Health

ACKNOWLEDGEMENTS

The authors wish to acknowledge the valuable services of Mr. Joseph Nelson, New Jersey State Health Department Laboratory, and Mr. John Wilford, Division of Environmental Health, in obtaining water samples and chemical determinations. Thanks are also due to Miss Gloria Conner for typing the manuscripts.

BIBLIOGRAPHY

1. Elliott, M. B. and Alexander, E. A.: *Circulation*, 23:563 (April 1961)

2. American Heart Association Nutrition Committee: *The 1,000 Milligram Sodium Diet*, American Heart Association, New York (1958).

3. Cole, S. L.: Annals of Western Medicine and Surgery, 5:177 (1951).

4. Bailey, K. R.: Journal of South Carolina Medical Association, 34:413 (1958).

5. Laubusch, E. J. and McCammon, C. S.: American Journal of Public Health, 45:1337 (October 1955).

6. Nachod, Z. and Schubert, M.: *Ion Exchange Technonogy*. Academic Press, New York (1957).

7. Bills, C. E., McDonald, F. G., Niedermier, W., Schwartz, M. D.: Journal of American Dietetic Association, 25:304 (April 1949).

8. Sodium Restricted Diets, the Rationale, Complications *and Practical Aspects of Their Use*. National Academy of Sciences, National Research Council (1954).

Academy Library Acquisitions

Following is a list of miscellaneous books on file at the Academy of Medicine Library, 307-17 Belleville Avenue, Bloomfield:

Essex County Medical Society. Constitution and by-laws of the Essex County Medical Society, as revised and adopted May 10, 1962. East Orange, 1962.

Hawken, W. R.: Photocopying from bound volumes; a study of machines, methods, and materials. Chicago, Library Technology Project, American Library Association, 1962.

Heyman, M. M.: Effective utilization of social workers in a hospital setting. Chicago, American Hospital Assoc., 1962.

Joint Committee on Mouth Protectors. Report. Washington, D. C., 1962.

McClure, F. J.: Fluoride drinking waters; a selection of Public Health Service papers on dental fluorosis and dental caries; physiological effects, analysis and chemistry of fluoride, Bethesda, Md., U.S. Public Health Service, National Institute of Dental Research, 1962.

U. S. President's Council on Youth Fitness. Youth physical fitness; suggested elements of a school-centered program. Washington, 1961.

Margaret Brisco, M.D.

Gerard Cicalese, M.D.

Newark

Rupture of the Gravid Uterus

An Eleven-Year Survey

Rupture of a pregnant uterus is rare—the incidence here was only one in 2,000; but when it occurs it is an emergency requiring prompt diagnosis and swift intervention.

A survey was made in the obstetrical department of the Newark City Hospital, to evaluate the ruptured pregnant uteri over an 11-year period ending in 1959. During this period, 12 uterine ruptures were found. This amounts to one in each 1947 deliveries.

One maternal death occurred in our series, a mortality of 8.3 per cent in the mothers. Ten fetal deaths were encountered, a fetal mortality incidence of 87 per cent. The youngest patient was 21; the oldest was 34.

Six of the twelve patients had previous cesarian sections. There was one rupture of the uterus due to obstetrical trauma and one due to injudicious use of pitocin infusion. Previous cesarian section scars accounted for six ruptures. Cephalo-pelvic disproportion accounted for one rupture with the remaining three believed to be due to multiparity. Previous cesarian section and multiparity seem to be important etiologic factors.

Among the patients with previous cesarian sections, four were *not* in labor at onset of uterine rupture; one had had three hours of labor. Only one had a history of ten hours of labor previous to onset of rupture. These data confirm the observation that the ruture usually occurs close to, or at, term but before labor actually starts; or at the very early onset of labor.

Of the six patients with no previous cesarian sections, five had a labor duration from two to 16 hours. One was not in labor at all.

The one patient who was given pitocin infusion was a gravida 5. Rupture started 3½ hours after the onset of the infusion. This went unrecognized and the infusion was discontinued some two hours later. Two other patients had labor of about 10½ hours prior to rupture. Of these, one was a gravida 5 whose rupture was attributed to multiparity. The other was a gravida 2 whose rupture was attributed to cephalo-pelvic disproportion. One other rupture was of a gravida 10 who was never in labor. The cause of this rupture was never determined.

The one maternal death was a gravida 7 who remained in labor for 16 hours. She presented a picture of abruptio with bleeding of moderate degree, which was probably evidence of the onset of rupture.

The one traumatic rupture was due to internal podalic version for a dead fetus shoulder presenting at 34 weeks gestation.

In our findings we have noticed that signs of fetal distress detected by means of fetal heart changes and loss is an early and constant sign of uterine rupture.

Pain (which must be differentiated from pain associated with rhythmical contractions in labor) was also an early and constant sign

of uterine rupture and was absent in only one of our patients.

The onset of the pain is *not* necessarily sudden and sharp. Apparently, most of the time, this pain gradually increases in severity. External bleeding is an unreliable sign which may not be present. It varies from only spotting to profuse hemorrhage, resulting in profound shock.

Shock is a late sign and was not present in four of our 12 cases. When shock becomes apparent, it could be irreversible and too late to save the patient.

The symptomatology in these patients which could have been attributed to uterine rupture lasted anywhere from 2 to a maximum of 78 hours before exploratory laparotomy was done. All had laparotomies except one patient who was diagnosed only at autopsy. On 7 patients, a sub-total hysterectomy was done. Four had a repair of the rupture area. One patient was undelivered and diagnosed on post-mortem examination. In 11 of the 12, the ruptures were complete.

From these findings, it is clear that rupture of the pregnant uterus is not always acute in onset. Sometimes diagnosis may be difficult. However, the triad of fetal distress, abdominal tenderness and subjective sign of pain associated with some of the etiologic factors mentioned above (including previous cesarian sections, and high multiparity) warrant a consideration of uterine rupture and a differential diagnosis of the problem.

Here are three typical cases:

CASE ONE

A 34-year old gravida 9 para 6 was admitted at 10:00 a.m. This was a pregnancy at term in early labor. She had a history of seepage of amniotic fluid for two days prior to admission; rest of history was otherwise uneventful.

Uterine contractions on admission were mild and irregular. Fetal heart rate was 152 LLQ. The cervix admitted a finger tip. Vertex was presenting at -1 Station. No seepage of fluid was noted. She continued to have mild irregular contractions during the day. No changes in cervical dilatation noted. She rested comfortably that evening but at 5:00 a.m. the following morning, she reported sudden rather sharp "gas pains" in the epigastrium which became steady. Epigastric distress became increasingly more severe and fetal heart tones were inaudible by 11:00 a.m. All vital signs were normal at this time. Contractions continued at irregular intervals. Temperature, pulse and blood pressure were normal. There now was some tenderness in the epigastrium with some guarding and rebound noted. The cervix was 3 centimeters dilated with vertex at 0 station. At this point, a surgical consultation was reported as "no acute surgical abdomen." The possibility of placental abruption was considered. Conservative therapy was continued. At 8:00 p.m. that evening, she complained of severe epigastric pain. Blood pressure remained at 120/80; and pulse was 104. A mass about the size of a grapefruit was now felt in the epigastrium and was thought to be a fibroid.

During the next two days, the pain subsided and therapy was conservative. On the fourth day after admission, at 4:00 p.m., sudden severe abdominal pain recurred and at this time small parts were felt very close to the abdominal wall. X-rays revealed single fetus with vertex well in the pelvis and signs of intra-uterine death. The abdomen became slightly distended. The diagnosis now was ruptured uterus.

On exploration, a term fetus was found with buttocks and feet extruded through the fundus of the uterus into the peritoneal cavity. The remaining portion of the fetus was in the uterus which was tightly contracted about the waist of the fetus. The placenta was within the uterine cavity. Little bleeding was encountered and a subtotal hysterectomy was done. The patient made an uneventful recovery and was discharged on the tenth postoperative day.

Seventy-eight hours had elapsed between onset of rupture and surgical intervention. No evidence of shock was noted at any time. All vital signs remained normal and blood counts showed no appreciable change since admission. The only signs of possible rupture were loss of fetal heart tones, severe epigastric pain and tenderness and palpation of buttocks and small parts in the epigastrium.

CASE TWO

A 30-year old, gravida 13, para 7, ab 5, very obese woman was admitted to the labor and delivery department at 9:30 a.m. with pitting pretibial and pedal edema and 3 plus albuminuria. At this time, the uterus was somewhat tense with mild intermittent contractions every eight minutes lasting 20 to 25 seconds. Due to the enormous size of the patient, it was very difficult to evaluate uterine contractions. The cervix was 1 finger dilated and the vertex was at -2 station. No bleeding or seepage of fluid noted. The patient gave a history of onset of pain four hours prior to admission. Our provisional diagnosis was severe pre-

eclampsia with premature separation of placenta and intra-uterine fetal death.

The patient was treated vigorously for her toxemia with magnesium sulfate, diuretics, antihypertensives and sedatives. The usual blood studies were done.

Contractions improved and at 12:30 p.m. membranes ruptured spontaneously and a port wine-colored amniotic fluid was obtained. At 1:30 p.m. her condition remained the same with continued bloody seepage of fluid. Vertex remained at -2 station with 2 to 3 centimeters cervical dilatation. Blood pressure remained at 160/100 and intramuscular Apresoline® (40 milligrams) was administered. By 2:30 p.m. her blood pressure had dropped to 90/50. It returned to 110/70 in 20 minutes. This drop was attributed to the Apresoline® and, therefore, was not thought to be due to anything serious. Uterine contractions continued and slight vaginal bleeding continued. Blood transfusions began at 6:00 p.m. This was given because of a low hemoglobin. Estimated blood loss at this time was not appreciable and all vital signs were within normal limits.

At 7:30 p.m., rectal examination revealed a cervical dilatation of 7 centimeters; vertex presenting at -1 station. Blood drawn at this time showed normal clotting mechanism.

While the patient was on the delivery table, her blood pressure dropped to 85/40 with a pulse of 104. A cut down was performed and another transfusion started so that two pints were now running. Blood pressure dropped to 0 and the patient died.

Autopsy revealed a lower uterine segment rupture with the buttocks and genitalia of the baby protruding through this rupture and the fetal back lying on the left side of the maternal abdominal cavity. The infant's head was cork-screwed and presenting in the ROP position, at plus 1 station. The placenta was intact. A large hematoma extended into the right broad ligament.

The fall in blood pressure initially did not come from the medication as thought, but was due to maternal rupture and blood loss. The continuance of uterine contractions made us believe that progress was being made. This did not lead us to recognize rupture of the uterus. Replacement of blood was delayed as clinical evidence did not make it seem urgent.

Many of our patients do not attend our prenatal clinic. They come directly into the hospital when in labor. Many are anemic and low counts are not considered as warranting immediate blood replacement. The unusual position of this fetus suggested that it might have been primarily a transverse lie as in early labor the vertex was quite high. Due to obesity, presentation was not confirmed until late in labor when the vertex was in the pelvis. Progressive but slow dilatation continued our conservative management. The diagnosis of ruptured uterus could not have been readily made early in the course of this labor.

CASE THREE

A 29-year old gravida 4, para 3 was brought to labor and delivery at 7:20 p.m. at about 30 weeks' gestation. Bleeding profusely from the vagina, she was cold and clammy on touch with no audible blood pressure and no fetal heartbeat. Small parts were thought to be felt directly and seemed to be superficial under the abdominal wall. Intravenous Dextran® was started. She was crossmatched for four units of blood and taken directly to the operating room. Tentative diagnosis was ruptured uterus or placenta previa. No accurate history was obtained as no member of the family was present at this time.

A low mid-line scar was seen on the abdomen and we thought that this might have represented a previous cesarian section. A history subsequently revealed the following:

The patient had experienced intermittent painless bleeding for the past two weeks prior to admission. She was treated with bed rest by a private physician. Just prior to admission, she began bleeding heavily but experienced no pain. Bleeding became profuse and by the time she reached the hospital, she was in deep shock and practically moribund.

At lapartomy, the uterus was found to have two incomplete tears in the anterior aspect of the lower segment at the left angle of the previous low cervical scar (which seems to be the case). The rupture was through all layers of the lower segment but the bladder peritoneum was intact. Placenta was attached directly under this area and had been partially separated.

Following delivery and closure of the uterus, the uterus failed to contract properly and a sub-total hysterectomy was done. The operative procedure took one hour and 30 minutes and the patient's blood pressure and pulse were absent until 45 minutes following beginning of surgery.

After a somewhat stormy convalescence, the patient was discharged recovered.

It is interesting to note that no pain was experienced with this incomplete rupture.

SUMMARY

1. In an 11-year period, there were 12 cases of ruptured uterus at the Newark (N.J.) City Hospital. This is an incidence of about one in 2000. Fetal mortality was 87 per cent; maternal mortality was 8.3 per cent.

2. Major predisposing factors were (a) considerable multiparity and (b) previous cesarian section.

3. For preventing mortality, swift diagnosis is essential. The time between the beginning tear in the uterus and its complete (or almost complete) rupture can be protracted.

4. A diagnosis of ruptured uterus should be considered in the presence of fetal heart changes, abdominal pain, and abdominal tenderness. The possibility should certainly be entertained when these signs develop in a woman who has had previous cesarian sections and many previous pregnancies.

5. Rupture usually occurs at term, generally before onset of labor, or in very early labor.

6. Surgical intervention is also necessary —either closure of the ruptured area or hysterectomy.

235 Delavan Avenue

The Hazards of Responsibility

Doctors are responsible for the great advance in medical care. In congratulating yourself on lessened morbidity and mortality, however, don't forget you are also responsible for the hazards of employing such potent therapy. You can't transfer this responsibility to the pharmaceutical industry as certain professors have attempted to do in testifying before the Senate Subcommittee. You may, however, see this responsibility transferred to Federal or state government by default unless you exercise your franchise as a citizen and become more active politically.—George E. Farrar, Jr., M.D., in *Resident Physician,* February 1963.

Hospital Dispensing

A behind-scenes effort to widen margins of safety for patients is beginning to take shape in hospitals across the land. It is a story of professions working together in an area that for years has been shaded by lawlessness, carelessness, and misuse of health skills. Playing leading roles are nurses, pharmacists, hospital administrators, lawyers, insurance investigators, physicians, state law enforcers, and federal fighters for poison control. Their common goal: reduce medication error.

Illegibility of prescriptions, showing that "the pen can be deadlier than the sore," has been attacked in handwriting courses welcomed by physicians in Chicago, New York and other cities. Unorthodox prescription symbols which lead to misinterpretation by druggists have been exposed by bulletin alerts in professional journals. Elderly patients, particularly prone to mistake, are receiving special medicine-taking instruction by physicians.

In one community two patients died of overdoses of a digitalis preparation last November when a pharmacist thought the prescriber's symbol, "Q.O.D." stood for "four times a day." The physician intended "one every other day." Actually, pharmacy has no such symbol; investigators believe it was "invented" by resident physicians in a nearby institution.

It is in the hospital, particularly in the large majority which have less than 100 beds, that current efforts are underway to strike back at medication error. A mighty blow is needed. For, the American Society of Hospital Pharmacists reports that in more than half of the 7,000 hospitals in the U. S. (including state and federal hospitals) potent drugs are being dispensed daily in violation of state pharmacy laws. Hospitals buy 20 to 30 per cent of prescription drugs sold in the U.S., and in 55 per cent of these institutions there is no pharmacist control over drug dispensing. Chief victim is the patient.

—April 1963 issue of *Medicine at Work* (Washington 5, D.C.)

Charles A. Furey, M.D.

Lakeland

Clinical Indications for Electromyography*

Ninety per cent of physicians, says Dr. Furey never have heard of electromyography. If this applies to you, here's an opportunity to fill the gap.

Electromyography is a firmly established diagnostic aid, similar in this respect to electrocardiography and electroencephalography. Progressive development of this field has come about, in part, as a result of research in electronics and electrodiagnosis. There have also been dramatic strides in clinical utlization of electromyography in the post-war years. In spite of this, most physicians are still unaware of the wealth of information (diagnostic, prognostic and confirmatory) obtainable with this procedure. Indeed, only 10 per cent of a representative group of physicians were acquainted with the very word "electromyography" according to a recent survey. It is appropriate, therefore, to describe briefly the subject, the instrument itself, and the method of use, together with the indications for and advantages of electromyography in clinical practice.

Electromyography deals essentially with measuring the electrical currents generated by muscles. The instrument (the electromyograph) together with correct interpretation of the recorded findings (the electromyogram) aid the physician in assessing the functional integrity of the neuromuscular system. Interpreted in conjunction with the clinical findings, electromyography assists in the diagnosis, prognosis and treatment of neuromuscular disorders.

The electromyograph itself is a compact unit. The apparatus consists of an intake cable to transmit action potentials from a needle electrode that has been introduced into skeletal muscle. The cable is attached to a preamplification system, a sound amplifier, loud speaker and cathode ray oscilloscope. A tape recorder and synchronized camera complete the equipment. By utilizing the composite unit, the electrical activity of normal and abnormal muscles can be seen, heard, recorded and photographed.

Any patient suspected of disease or disorder of the neuromuscular system should have the benefit of electromyography as part of the diagnostic workup. This will include a variety of diseases and disorders that involve the anterior horn cells, nerve roots and root plexus and peripheral nerves.

The distinctive advantage of electromyography as a diagnostic procedure is this: the characteristic abnormal action potentials indicative of disease can be perceived only by electromyography. Every cardiologist knows that there are coronary T waves detectable only in the electrocardiograph; that no matter how astute a clinician he is, he is not going to detect these by physical examination. Similarly, certain findings can be perceived only through electromyography.[1,2]

The clinical advantages of this diagnostic aid may best be pointed out by citing examples of disorders with which the physician frequently comes in contact. Electromyography is

*This work is from the Camden County (N.J.) General Hospital where the author is Director of Physical Medicine and Rehabilitation.

1. Golseth, James G.: California Medicine, 87:298 (Nov. 1957).

2. Marinacci, Alberto A.: *Clinical Electromyography*, San Lucas Press, Los Angeles, 1955.

indicated as a diagnostic procedure in *all* disorders of the neuromuscular system. But there are three common signs and symptoms in which the diagnosis is frequently obscure and in which the electromyogram is particularly helpful in clarifying the diagnostic problem. These signs and symptoms are atrophy, weakness and fatigue.

ATROPHY

MUSCLE atrophy is often a diagnostic problem because there are several types that resemble one another. These include the disuse, neurogenic and myogenic variety. However, with the electromyogram, establishing a diagnosis is simplified.

Muscle atrophy of the *disuse* type follows what is frequently described as prolonged immobilization. It may also occur in as short a period as ten days; for example, when a deltoid muscle is restricted due to shoulder injury and subsequent immobilization. Disuse atrophy is characterized by reduction in the amount of sarcoplasm without loss of striation, degeneration of muscle fibers or changes in electrical response; and no degeneration of intramuscular nerves or their endings occurs.

Atrophy also occurs in *lower-motor-neuron disease*. This is called "neurogenic" muscle atrophy. There are two general types: spinal and neural. The spinal variety occurs in diseases such as anterior poliomyelitis and the like. Neural atrophy is seen in polyneuropathy, neuronitis, and mononeuropathy.

Myogenic atrophy is the result of a disease of the muscle fibers *per se* or of the myoneural junction. This group includes muscular dystrophies and myesthenia gravis, as well as myotonia congenita, aquisita and atrophica.

In many of these neuromuscular disorders, where atrophy is the principal (and perhaps the only) clinical finding, it is often difficult and sometimes impossible to establish the diagnosis on clinical grounds alone. On the electromyogram, each disease entity presents a classical picture. Where diagnosis has been established clinically, the electromyogram confirms it. The procedure is also an excellent way of objectively following the patient's progress just as serial cardiograms assist in confirming diagnosis, following progress and directing treatment in a patient with coronary occlusion.

WEAKNESS

WEAKNESS, particularly when persistent, is a frequent precurser of more serious disease. At times, it may be a puzzling complaint. Weakness may be the key sign to one of a great variety of upper-motor-neuron disorders, such as cerebral-vascular-accident, cranial neoplasm and the like. Or it may be associated with such lower-motor-neuron disorders as poliomyelitis, progressive spinal muscular atrophy or amyotrophic lateral sclerosis. In the presence of weakness, the electromyogram assists first in differentiating the disease under investigation (as being either of the upper or lower-motor-neuron type); and if the weakness is due to lower-motor-neuron pathology, the electromyogram aids in localizing the lesion in the anterior horn cell, spinal-nerve-root, nerve plexus or peripheral nerve.

FATIGUE

ANY patient complaining of chronic and abnormal fatigue is a candidate for an electromyogram. Fatigue is a dangerous and insidious symptom of certain disorders involving the neuromuscular system. Dangerous, because it is frequently a pilot of what later proves to be a chronic disorder involving this system; insidious, because in the early stages (when establishing the diagnosis is most important) there may be few, if any, objective findings. Electromyography helps establish the complaint of fatigue as referable to the neuromuscular system, in indicating the motor units principally involved, in assessing the degree of involvement and thereafter providing an objective method of assessing progress.

In light of the contribution to diagnosis made by electromyography, physicians are coming to realize that chronic fatigue frequently reflects organic involvement of the neuromus-

cular system in its early states. Many physicians have suspected this in the past, but they have had no means of confirming, other than the test of time itself.

INFECTIOUS neuronitis is one example of a neuromuscular disorder in which chronic fatigue is a frequent complaint, and in which establishing the diagnosis on clinical grounds alone is difficult. The electromyogram assists in establishing the diagnosis in this disorder, in which the clinical manifestations are often limited and in which the clinician sees but a fraction of the true picture. Until more than 30 per cent of the lower-motor-neurons are affected, the clinical manifestations are uncertain.[3] This clouded state usually leads to various opinions and speculative diagnoses. The electromyogram has been a substantial aid in the correct diagnosis by differentiating infectious neuronitis (for example) from its host of imitators. When there is a paucity of clinical findings, there will be widespread electromyographic findings. Even in the absence of clinical signs (where subjective symptoms alone are present) electromyographic changes are shown to exist in this condition.

Further indications for employing electromyography in diagnosis are in disorders of the extremities.

THE UPPER EXTREMITY

COMMON disorders of the upper extremity, in which the electromyogram offers definite diagnostic assistance [4] include cervical-root syndrome due to disc disease, cervical tumors, vascular abnormalities and the like; nerve-compression-syndrome involving the long thoracic nerve or brachial plexus, the result of trauma from athletic injuries; scalenus anticus syndrome, cervical spondylosis, apophysitis and peripheral nerve injury.

The electromyogram also offers an excellent, accurate and an earlier method by which to follow the course of regeneration after peripheral nerve injury. Furthermore, the electromyogram is helpful in differentiating the pain of primary shoulder disorder (bursitis, tendonitis and the like) from shoulder pain referred from an involvement of the brachial plexus, axillary-nerve or cervical nerve roots.[5] In painful shoulder cases of the type mentioned, the electromyogram assists the roentgenologist in selecting the patient who will benefit from roentgen therapy. The electromyogram can improve postoperative results by contributing diagnostic information that will allow for greater selectivity of cases.

THE LOWER EXTREMITY

IN THE lower extremity, the electromyogram is of distinct diagnostic or differential aid in the following: Root-compression-syndrome due to herniated nucleus pulposus, tumor or vascular phenomenon; in polyneuritis [6] due to alcohol, chemicals, certain infections, or spinal anesthesia; in peripheral nerve injury and other nerve compression and/or contusion syndromes such as peroneal palsy. Injury to the peroneal nerve may be the result of direct trauma, especially in the region of the neck of the fibula, or to fracture of the leg, or compression from prolonged sitting with crossed knees. This condition also occurs in the neuritis associated with Charcot-Marie-Tooth disease. In all these conditions, an electromyogram may be helpful to the clinician.

The electromyogram offers an excellent, accurate and earlier method than has been available heretofore, by which to follow the course of nerve regeneration after peripheral nerve injury.

SUMMARY

IN RECENT years, electromyography has progressed from the field of research to a tried and proved procedure. Today it offers the

3. Marinacci, Alberto A.: Journal of Los Angeles Neurologic Society, 21:37 (March 1956).
4. Furey, Charles A.: JOURNAL of The Medical Society of N. J., 54:74 (Feb. 1957).
5. Furey, Charles A.: In *Clinical Orthopaedics* (J. B. Lippincott Co.) 1958. (Volume 12)
6. Marinacci, Alberto A.: Journal of the American Medical Association, 168:1337 (Dec. 1958).

clinician distinct assistance in the differential diagnosis of a variety of disorders involving the neuromuscular system. It yields positive information and valuable objective evidence, as in the examples cited, of lower-motor-neuron disease that can neither be controlled by the patient nor observed clinically through the intact skin by the physician. Progress has been so rapid in this field that there is need to acquaint the medical profession with the distinct advantages and usefulness of electromyography in clinical practice. Every patient suspected of disease or disorder of the neuromuscular system, should have an electromyogram.

Camden County General Hospital

Medical Defense Course

If you are willing to spend a week in Alabama, you may be interested in courses in CBR warfare and CBR defense. CBR means: chemical, biologic, radiologic. The courses are given at Fort McClellan, Alabama. The next three classes are:

December 9 to 14, 1963
February 10 to 15, 1964
April 6 to 11, 1964

There is also a two-week course, June 8 to 20, 1964.

These courses will help provide the training required to develop chemical, biologic and radiologic defense capability for public health and medical personnel within the states, counties, and municipalities, agencies and organizations. Throughout the courses the student is imbued with the urgency of adequate training, prior planning for chemical, biologic and radiologic defense, and development of a program to continue essential activities in the event of disaster. The courses will include detailed instruction in the following subjects:

a. Current capabilities of chemical, biologic and radiologic agents and munitions systems.
b. Defensive technic including planning, organization, material, and defensive operations.
c. Public health aspects of CBR* warfare.
d. Detection and identification of CBR* agents.
e. Survey and delineation of contaminated areas.
f. Radiologic survey and monitoring methods.
g. Decontamination materials and technics.
h. First aid and treatment for CBR* casualties.
i. Care and use of defensive equipment.
j. Fallout prediction.
k. Psychologic aspects of CBR* weapons systems.

The courses are directed to civilian needs and security clearance of the students is not required.

A course manual, including lecture outlines and additional resource materials, will be distributed to all course participants.

The second week of the June course will be devoted to radiologic defense. The class will begin on Monday morning and terminate at noon on Saturday of the second week.

Participants are expected to plan their travel arrangements to permit them to attend all sessions of the courses.

The courses will be conducted in cooperation with the U. S. Army Chemical School at Fort McClellan, Alabama. The school is a modern air-conditioned plant with excellent laboratory facilities and a variety of ranges, exercise and demonstration areas. Most noteworthy is a radiologic survey training area which, by use of gamma sources, allows realistic training in radiologic ground and air survey during the two-week course in June 1964.

Fort McClellan is near Anniston, Alabama. Those who attend the course will be housed in governmental quarters, at a cost of $1. per night. Government eating facilities are available at about $3 per day. There are adequate hotel and motel accommodations in the vicinity for students desiring to bring families.

Participants will be individuals with responsibility in chemical, biologic and radiologic defense. They will include representatives of health departments, faculty members of affiliated schools in the Medical Education for National Defense Program, Veterans Administration, Public Health Service, and other interested individuals. A maximum enrollment of 40 students for each class is suggested.

Application for attendance is directed to the Deputy Chief, Training Branch, Division of Health Mobilization, Public Health Service, U. S. Department of Health, Education, and Welfare, Washington 25, D. C. Enrollment forms are available from Deputy Chief, Training Branch.

* CBR means Chemical, Biologic and Radiologic.

Dave B. Swerdlow, M.D.

Lawrence Ulvestad, M.D.

Orange

Oophorectomy in Cancer of the Large Bowel*

Experience dictates the wisdom of bilateral oophorectomies in all women over the age of forty with carcinoma of the large bowel.

Recently our surgical service* has noted several cases of unique symptomatic metastatic carcinoma to the ovaries from large bowel malignancies. This raised the question of the frequency relationship of gastrointestinal tumors and ovarian metastases to determine the advisability of bilateral oophorectomy as a part of our cancer operation. This is particularly a problem in lesions of the colon and rectum in female patients over the age of 40.

Burt [1,2] advocates "prophylactic oophorectomy with resection of the large bowel for cancer." He reports 17 of 439 (3.4 per cent) patients with carcinoma of the large bowel having metastases to the ovary. In 13 of the 17 cases the ovary presented the *only* evidence of metastases from the primary tumor.

Karsh [3] reported on over 10,000 autopsies from 1925 to 1949 and cited secondary neoplasms in one or both ovaries in 72 cases. This is an incidence of 0.7 per cent. Of these cases, 20 were from the gastrointestinal tract. Ten were from the large intestine, eight from the stomach, one from the liver, and one from the gall bladder. Thus, more than one-fourth of these reported cases arose from the gastrointestinal tract, most of them from the large intestine.

Rendelman and Gilchrist [4] cite an experience similar to ours that motivated this report. They discuss a patient operated on for a malignancy of the colon who had a second and third procedure for the removal of large masses. Each subsequent operation was for the removal of metastatic disease to the ovary. These authors cite 13 cases of secondary cancer in patients operated for carcinoma of the gastrointestinal tract. Two had their primary sites in the stomach; the other eleven in colon and rectum. One hundred and two resections of female patients were done during the six years prior to 1959. Forty-two had bilateral oophorectomy. Their criteria for oophorectomy were: adherence to the ovaries or uterus, abnormal appearance of the ovaries, and serosal invasion or peritoneal implants of the primary tumor. They also did oophorectomy in all palliative resections. None of these 102 required a second operation for the removal of a metastatic ovarian lesion.

In the Orange Memorial Hospital Unit of the Hospital Center at Orange, 13 cases of

*From the Department of Surgery, Orange (N.J.) Memorial Hospital.

1. Burt, C. A.: Diseases of the Colon and Rectum, 3:352 (July 1960).
2. Burt, C. A.: American Journal of Surgery, 82:571 (1951).
3. Karsh, J.: American Journal of Obstetrics and Gynecology, 61:154 (1951).
4. Rendelman, D. F. and Gilchrist, R. K.: Surgery, Gynecology and Obstetrics, 109:364 (1959).

ovarian metastatic malignancies were reported after 1951. They included seven from the colon and rectum, two from the uterus, two from the stomach, one from the breast, and one of unknown origin. From 1956 to 1961, second operations were done on four patients previously operated on for malignancies of the colon. These women had large symptomatic masses found to be ovaries engorged with metastases. Upon searching through the records of surgical procedures for this five-year period, we see that 101 resections for carcinoma of the large bowel were performed on females. All were over 40 years of age. This suggests that in about four per cent of our cases, second operations might have been prevented if bilateral oophorectomy had been done at the time of the original surgery.

Metastatic tumors to the ovaries do not occur with great frequency. However, our impression concurs with that of other authors in that we add our plea for cancer operations for large bowel malignancies in female patients over 40 to include bilateral oophorectomy. This procedure is simply and quickly performed. It adds little or no risk or morbidity and may increase the comfort and perhaps the survival of these patients.

188 South Essex Avenue

Medical Radio Network

In Boston, physicians prepare to tune in a private radio network for medical information. In six midwestern states, radio operators help speed bequeathed eyes to surgeons for corneal transplants. In Caracas, Venezuela, "ham" operators initiate a call for aid to Washington, D. C. These are among recent stories of communications for better health.

The Boston physicians are subscribers to the new Medical Radio Network. Plans early this year called for closed circuit facilities to provide music for doctors' waiting rooms and 15-minute medical programs broadcast directly into their offices. Similar programs are proposed in 30 other cities.

The "Eyeball Network" joins radio "hams" near 10 eyebanks. Their efforts in relaying requests for eyes are credited with success in five emergency cases in recent months.

A different network recently carried another story of help via radio. As told on NBC's "Three-Star Extra" news roundup, the mercy mission aided a young Venezuelan father of three who was stricken with leukemia. At his physician's request, "ham" operators relayed a call for assistance to Project HOPE's Washington, D. C., headquarters. Officers of the privately-financed medical diplomacy program notified Eli Lilly and Company of Indianapolis, where anti-leukemia drugs are under experimentation. Lilly officials arranged to airlift some to Venezuela. The tablets were in the physician's hands just 24 hours after the first radio request.

This story of cooperation, summarized by NBC, "pulls aside the curtain of (the free enterprise system's) business-like exterior and permits us to see the true humanitarianism which lies beneath."

April 1963 issue of *Medicine at Work* (Washington 5, D.C.)

Value of Advertising

If there were no pharmaceutical advertising, new lifesaving drugs would be withheld from the critically ill patients, either because we the physicians did not know the new drug existed or we did not know its exact indications and how to administer it safely and effectively. The pharmaceutical industry is having to carry the Herculean load of protecting its livelihood, and providing the world with these lifesaving remedies.

Troy A. Shafer, M.D., Chairman, Board of Trustees, Texas Medical Association, in *Texas State Journal of Medicine,* Oct. 1962.

EDWARD N. BOOKRAJIAN, M.D.

North Bergen

Septic Abortion with Bacteremic Shock*

Septic abortion is a still too-common, and too often tragic, complication. Dr. Bookrajian here suggests a swift treatment program.

SEPTIC abortion has assumed a position of increasing importance at the Jersey City Medical Center because of a relative increase in incidence. A more disturbing reason for this gain in importance is the increasing number of critically ill patients that comprise these admissions. Many of these with pelvic infection fail to respond to massive antibiotic therapy because of antibiotic-resistant strains of the common pathogenic bacteria. A further cause for concern is that an increasing number of these septic abortions exhibit an associated bacteremic shock of varying degree, some of which are of sufficient severity to terminate in death. Since Studdiford and Douglas'[1] 1956 report, attention has been focused on this newly-recognized syndrome of septic shock because of its high mortality. It is for these reasons that I present a history of septic abortion with bacteremic shock, in order that the typical clinical picture may be portrayed and its management discussed.

A 32-year old gravida 3, para 3, with no previous abortions was admitted at eight a.m. through the emergency room. Vaginal bleeding, lower abdominal cramps and chest pain were present since 11 p.m. of the previous day. Soon after arriving in the examining room, the patient spontaneously expelled a macerated fetus measing 12 centimeters with cord attached and a placenta measuring 9 by 6 by 3 centimeters, with an estimated blood loss of about 400 cubic centimeters. Admission temperature was 98.6; the pulse was 102, and blood pressure was 100/60. She seemed acutely ill, uncooperative and secretive. Examination disclosed diffuse lower abdominal tenderness, slight rebound tenderness, and muscle guarding. The fundus of the uterus was palpated above the symphysis.

After blood was drawn for laboratory studies and a cervical culture was taken, initial treatment consisted of an infusion of 1000 cubic centimeters of five per cent glucose containing two ampules of Pitocin® in one arm, and 500 cubic centimeters of whole blood in the other arm. In addition 100 milligrams of Demerol®, and 1/320 grain of Ergotrate® were also given intramuscularly. Initial red blood count was 4,590,000, hemoglobin concentration 14 Grams, and leucocyte count was 6300.

During the next 12 hours, her condition appeared progressively to deteriorate despite the lack of significant blood loss. She became cold, clammy and restless, the blood pressure dropped to 60/40, and pulse was barely discernible.

Neosynephrin® (phenylephrine) two amples to a 1000 cubic centimeter infusion, and subsequently Aramine® (metarminol), four ampules to a 1000 cubic centimeter infusion were used to combat the hypotension. Antibiotics in the form of penicillin 1,200,000 units and dihydrostreptomycin 0.5 Gram were ordered to be given twice daily. The patient's condition failed to improve and on the following day 500 cubic centimeters of whole blood were administered, and 100 milligrams of Solu Cortef® and one Gram of Chloramphenical® were added to the infusion, and intranasal oxygen was started. The penicillin, the streptomycin and the Aramine® were continued as previously. This therapeutic regime, with the exception of additional blood, was continued for the ensuing five days. Despite this, the patient remained hypotensive, the systolic blood pressure varying between 40 and 80; the temperature was elevated between 101.4 and 102.4. Pulse varied between 90 and 100 and was of poor volume.

The blood culture was sterile. Urine culture showed a growth of streptococcus coagulase and Aerobacter with an insignificant colony count. The cervical culture was reported as B. Proteus over-

*Read by invitation, December 8, 1962 before the New Jersey Chapter, American College of Surgeons.

1. Studdiford, W. E. and Douglas, G. W.: Am. J. Obst. and Gynec., 71:842 (1956).

growing staphylococcus, and was sensitive to chloramphenical, dihydrostreptomycin and Kanomycin®. Because of the cervical culture and sensitivity reports, no change was deemed necessary in the antibiotics being given. Electrolyte studies, blood chemistry, the carbon dioxide combining power, as well as repeated hematocrit studies, remained within normal limits. The one bright feature about the clinical picture was that the patient was maintaining an adequate daily urinary output. Her condition remained critical until the sixth day of her admission. From the sixth day on she showed gradual improvement and was discharged on the tenth day.

It is apparent from this case history that bacteremic shock as seen in septic abortion is characterized by a critically ill and prostrate patient, with a systolic blood pressure ranging from 40 to 80, a rapid, thready pulse with poor volume, and fever. In some instances, the fever is replaced with a hypothermia, and there may be leucopenia or extreme leucocytosis. The peripheral vascular collapse is believed to be caused by the action of a bacterial endotoxin,[2,3] resulting in a marked vasodilation, a decrease in effective blood volume, and a diminished cardiac output; and if the peripheral circulatory failure remains uncorrected, progressive circulatory deterioration and eventual death will ensue.

The organisms which elaborate an endotoxin usually belong to the gram-negative coliform, or so-called enterobacterial groups. These include E. Coli, the Proteus, the Enterococcus, the Pseudomonas aerogenes, and the Aerobacter aerogenes. It should be stated that, although the occurrence of shock is much more common following gram-negative bacteremias, it may occasionally be caused by gram-positive infections.[4] It has been suggested that the mechanism of shock in the latter instance may be due to a bacterial hyper-sensitivity reaction, since endotoxins have not been shown to exist in gram-positive organisms.

Most cases of septic shock follow induced or criminal abortions. A few do occur in spontaneous abortions. Early recognition with proper and intensive treatment must be instituted if death is to be averted. One of the pitfalls in the management of these patients is overtransfusion with its danger of cardiovascular decompensation because of lack of recognition that the shock is a result of the septic state rather than blood loss.[5]

It is generally believed that death from this condition is related to the Schwartzman reaction.[6] The latter is experimentally produced in the animal by the administration of two doses of endotoxin given 24 hours apart. The first injection is the sensitizing dose, and the second injection is presumably responsible for the disseminated intravascular coagulation reaction throughout the body, resulting in death. In the pregnant animal, only one injection is necessary to produce death.

TREATMENT

1. Immediate cervical or intrauterine cultures and blood cultures should be taken before antibiotic therapy is commenced in all cases of suspected septic abortion.

2. Immediate removal of tissue that presents at the cervical *os* by sponge forceps is essential. This will frequently relieve pain and will often control bleeding until the uterus can be emptied at the most favorable time from the standpoint of safety to the patient.

3. Whole blood must be given to replace blood loss and combat shock due to blood loss. Careful and repeated evaluation of blood levels by hematocrit studies must be obtained to avoid over-transfusion with the danger of resulting pulmonary edema and death.

4. Antibiotic therapy is usually begun with an average daily dose of two to six million units of penicillin and one to four Grams of streptomycin. In the more serious cases, or in those in which there has been no clinical improvement in the first 24 hours, chloramphenicol, two to four Grams daily, is added to the therapy. Intravenous administration is to be preferred because of the more rapid,

2. Bennett, I. L., Jr. and Beeson, P. B.: *Medicine*, 29:365 (1950).
3. Thomas, L.: Ann. Rev. Physiol., 16:467 (1954).
4. Ezzo, J. A. and Knight, W. A., Jr.: Arch. Int. Med., 99:701 (1957).
5. Deane, R. M. and Russell, K. P.: Am. J. Obst. and Gynec., 79:528 (1960).
6. McKay, D. G., Jewett, J. F. and Reid, D. E.: Am. J. Obst. and Gynec., 78:546 (1959).

higher and more constant blood levels obtainable. When bacteriologic reports and sensitivity studies become available this regime may be altered, especially if the clinical response has not been sufficiently good.

5. Intravenous oxytoxic drip of Pitocin®, two ampules to 1000 cubic centimeters, should be given slowly if there appears to be large amounts of retained placental tissue, and/or uterine bleeding of sufficient severity to endanger the life of the patient. The hazards of Pitocin® as a potent shock producing agent must be kept in mind, and its use avoided whenever possible.

6. Dilatation of the cervix and evacuation of the uterus should be done as soon as the patient's condition permits, after 24 hours of routine antibiotic therapy. Ovum forceps, the large, blunt curette and the gauze-covered finger is to be preferred; and the sharp curette avoided whenever possible. The only exception to this rule is when septic abortion is associated with life-endangering hemorrhage. In such instances a dilatation and curettage should be done as an emergency procedure.

7. Early use of effective vasopressor drugs is essential when hypotension is present, not only to forestall irreversible shock but also to restore circulation before ischemia has damaged the kidneys, producing renal shutdown. Neosynephrin in the mild cases, and Aramine® and Levophed® (levarterenol) in the more severe cases should be used as a continuous intravenous drip, carefully monitered with the objective of maintaining a systolic blood pressure of 80 to 100. We prefer Aramine® to Levophed® because the former is less likely to result in dependence with reflex hypotension on withdrawal, and is said to promote renal blood flow more strongly. A further advantage is that Aramine® is not associated with a slough if there is extravasation, as sometimes occurs with Levophed®. The latter, however, has not been completely displaced in clinical practice, since it will maintain the blood pressure of patients refractory to Aramine®.[7]

8. Hydrocortisone is also advocated to combat varying degrees of adrenocortical failure. We feel this to be of inestimable value in some instances.

9. If there has been a high temperature with sweats (and especially if there has been associated vomiting) there may be a serious depletion of sodium, chlorides and potassium. These must be replaced to maintain proper electrolyte balance.

10. Derangements of the acid-base balance are a frequent and serious complication and should be watched for closely and corrected by intravenous infusion of the appropriate electrolyte solutions.

11. Oxygen therapy is of value to counteract tissue anoxia associated with reduced arterial blood flow characteristic of established shock.

We have no experience with hysterectomy as a method of management because we are not convinced of its value. Reid[8] states that it is proper to consider hysterectomy, preferably within 10 hours after the onset of shock, if the patient fails to respond to conservative measures. After that time, lesions consistent with the Schwartzman reaction may already be present, and the patient may well have reached an irreversibly moribund state.

Decreasing renal output and varying degrees of lower nephron nephrosis is an ominous and frequent complication.

8027 Hudson Boulevard

7. Martin, J. W. and McHenry, M. C.: Medical Clinics of North America, 46:1073 (1962).

8. Reid, D. C.: Clin. Obst. and Gynec., 4:999 (1961).

JOHN D. PREECE, M.D.

Trenton

Deaths Due to Septic Abortion

This is a report from the Special Committee on Maternal and Infant Welfare. Attention is also directed to the article by Dr. Bookrajian on page OO of this issue.

LAST year eight maternal deaths in New Jersey were due to sepsis. Seven occurred in septic abortions. To report only one death from sepsis in an entire year would have been a new all-time low in New Jersey maternal death statistics. It was tragic that there were an additional seven deaths due to septic abortion.

With the pregnant female protected by modern medicine as never before, it is sad that seven pregnant women died in New Jersey last year, through their own failure to seek early medical care. The following are typical case histories:

CASE ONE

This 29-year-old gravida 6, para 4 was admitted in the 15th week of gestation, with the complaint of abdominal pain. She had been well until three weeks prior to admission, when she had an induced abortion about which she refused to give any information. One week later, she developed a fever. A physician administered antibiotics and recommended hospitalization which the patient refused. Two weeks later the abdominal pains began, which prompted the patient to enter the hospital.

On admission, temperature was 100, pulse 160, and the respirations were 40. She was acutely ill. Physical examination was negative except for abdominal distention. The uterus and adnexa were not palpable due to the distension. She received antibiotics and intravenous fluids. Her condition became worse. Urinary output was minimal. On the sixth hospital day she developed Cheyne-Stokes breathing and died.

Autopsy revealed a purulent peritonitis and a purulent endometritis, with abscesses of both fallopian tubes.

CASE TWO

A 25-year-old gravida 5, para 3 was admitted with vaginal bleeding and abdominal pain of 48 hours duration. Her last menstrual period was seven weeks before admission.

On admission, her temperature was 102.4, pulse 90, and respirations were 24. The positive findings were on pelvic examination. The uterus was twice the average size. It was in second degree retroversion and extremely tender on palpation. The cervix was open and there was a purulent discharge from the os. The adnexal areas were painful on palpation.

The impression was that she had an incomplete abortion with uterine infection. Cultures from the cervix, from the blood, and from the urine were positive for *Clostridium welchii,* gas bacillus. The patient received large doses of penicillin and streptomycin on admission. She was given multiple blood transfusions, intravenous fluids, and cortisome therapy in the next two days. She died 45 hours after admission. There was no autopsy.

The woman suffering from an infected abortion presents one of the most desperate illnesses a physician will encounter. Treatment is immediate hospitalization and the implementation of all medical and surgical aids that are available.

For further discussion of this serious condition, see page 520 of this issue.

471 Bellevue Avenue

Psychosomatic Profile • • •

Free-Floating Anxiety

"Free-floating" anxiety may be, as Freud once suggested, a quantum of the stuff ready and able to attach itself to any suitable idea or circumstance. If so, perhaps the panicky patient—face drawn, mouth dry, pulse rapid, gut spastic, perspiring and trembling—represents merely a psychopathologic butterfly net, somehow destined to entrap each experience in the neurotic web. The remedy, then, is simple. Merely block the sympathetic, neutralize the motor impulses, inhibit the monoamine oxidases and add a few words about how bad things used to be or what it takes to be a man. When the regimen fails, as it does so often, can it be that the premise is not altogether sound? Is "free-floating" merely a comfortable cover for "origin not yet known"?

An attorney, aged 52, was thoroughly cleared of suspicion of hyperthyroidism, amebiasis, drug addiction and lupus. Anxiety was intense. After a few brief sessions in which facts were recorded and confidence tentatively established, he told in detail about his wife's recent mastectomy, his inability now to even visit a hospitalized friend, his sudden impotence and his feeling of doom. Concern about his wife's future, a measure of depression, expressions of grief—all would have been normal, even expected. There had to be more here. The "free-floating" anxiety, touching all phases of his life, had to have some roots.

The break came in the form of a vivid dream. There was a beautiful white motorboat. He was puzzled that his wife should have been driving although he was aboard. She maneuvered the craft through a narrow inlet and suddenly smashed the right front section of the hull. He remembered awakening, not angry at his wife but somehow, for a time, relieved. His association with the boat was—pleasure, sport, something good. White suggested—virginity, purity. "But why was she driving?" he asked repeatedly. "She never does." Then suddenly a light went on. "She was driving and it was her fault, not mine. I hadn't ruined the front of the clean, white thing!" He was soon able to see that what tortured him was massive, overwhelming guilt. He recalled a childhood in which sex was equated with filth. He recognized how conceptualization of his intimacy with his wife as a criminal assault resulted in his conviction that her body must inevitably be destroyed. It was not her pancreas which was diseased but her breast, an organ associated with love and lust. Obviously, then, the guilt was on his head and almost as a defense against the accretion of even more, he was rendered incapable of further sinful depredations.

Certainly, a great deal more had to be said and was, once the gates were open. But what had been "free-floating" had been anchored, both for physician and patient. The way to recovery was no longer a matter of blind ablation of reactivity through pharmacologic agents. Instead, the major dynamic theme, unique for this personality alone had been suggested. His anxiety, psychic in origin and largely somatic in expression, was thus largely understood and consequently well along toward resolution.

SANFORD M. LEWIS, M.D.

Diabetes Pamphlet Available

What You Don't Know Can Hurt You, a new physicians' waiting room pamphlet, prepared by the Ames Company, has just been made available for the medical profession to give to diabetics. The pamphlet deals frankly with the signs and symptoms of diabetes and the importance of detecting diabetes early. Attention is called to the 1,500,000 unknown diabetics, the warning signs of diabetes and the dangers of untreated diabetes. For copies for your waiting room, write to the Ames Company in Elkhart, Indiana.

Trustees' Meeting: September 15, 1963

A regular meeting of the Board of Trustees was held on Sunday, September 15, 1963, at the Executive Offices. For the full information of the membership, detailed minutes are on file with the secretary of each component society. A summary of the significant actions follows:

Hospital Utilization . . . Directed that the existing permanent committee on Blue Cross and Blue Shield Plans include hospitalization and its considerations and that the committee membership—which now has three members each from MSP, HSP, and MSNJ—be expanded to include representatives from the New Jersey Hospital Association.

Neurologic and Sensory Diseases Study . . Agreed to support this project—at the request of the Commissioner of Health—being conducted by the State Health Department and Jefferson Medical College, to establish a center at Jefferson for treatment of neurosensory disorders.

Poliomyelitis Immunization . . . Recommended to component societies that they support the Department of Health in the following project:

> With all three oral vaccines licensed, New Jersey has the opportunity substantially to eradicate poliomyelitis. Mass community campaigns are necessary. All New Jersey's people could thus be protected. The strong leadership, unequivocal endorsement, and active promotion by MSNJ offers an unusual opportunity. Many component societies are planning or discussing the operation of campaigns. There is plenty of experience now to demonstrate that such campaigns can be financed from costs assessed on the people getting the service. The State Department of Health has received a grant under the Vaccination Assistance Act. It proposes to devote the next year, for the most part, to achieving the benefits of high herd immunity against poliomyelitis through the oral vaccine given on a mass basis. The grant provides funds for staff. The grant does *not* provide funds for vaccines nor supplies, but these can more properly be paid for by the recipients of the protection.
>
> Commissioner Kandle asks: "Can we join forces and complete this important advance for the public health?"

Medical Assistants . . . Appointed Dr. Joseph R. Jehl of Passaic as an advisor to the New Jersey Association of Medical Assistants.

Veterinary Association . . . Approved the request of the Veterinary Medical Association of New Jersey to again co-sponsor a comparative medical meeting in the spring of 1964—and each succeeding year thereafter.

Committee on Medicine and Religion . . . Established—at the request of the AMA—a Special Committee on Medicine and Religion, with membership as follows:

Dr. Jerome G. Kaufman, President, Chairman
Dr. Luke A. Mulligan
Dr. Donald T. Akey
Dr. Thomas H. McGlade
Dr. John S. Madara

Seminar on Tuberculosis . . . Named Dr. Joseph A. Smith of Glen Gardner as the Society's official representative on an advisory committee of the TB Association coordinating a seminar on TB.

Reception for President-Elect . . . Approved the recommendation of the Annual Meeting Committee, as follows:

> That the Board of Trustees authorize a limit of $2,500 from the exhibit receipts each year for the reception honoring the incoming President; that the reception be handled by the MSNJ staff; that the invitations list MSNJ and the President-Elect's home county society as the sponsors; that the affair be open to all registered delegates, members, their wives, Auxiliary members, invited guests, and their wives; and that if the home county society wishes additions for the reception that the cost of these additions be borne by the home county society.

Golden Merit Award Reception . . . Approved the recommendation of the Annual Meeting Committee that "the future financing of the reception be charged to the Council on Public Relations."

Educational Exhibits . . . Approved the recommendation of the Annual Meeting Committee that "a nominal charge of $25 for booth equipment be made for each educational exhibit in the future—payment by the agency or organization it outside the Society and charged to the committee budget if within the Society."

Friday, May 15, 1964	(evening)	Board of Trustees
Saturday, May 16, 1964	(morning)	Registration opens
	(afternoon)	House of Delegates
	(evening)	Nominating Committee
Sunday, May 17, 1964	(morning)	Reference Committee
	(afternoon)	Installation of Exhibits House of Delegates
	(evening)	Reception for President-Elect
Monday, May 18, 1964	(morning)	Exhibits Open, three Scientific Sessions
	(afternoon)	Three Scientific Sessions
	(evening)	Annual Dinner
Tuesday, May 19, 1964	(morning)	House of Delegates, two Special Scientific Sessions
	(afternoon)	House of Delegates continued, two Special Scientific Sessions
	(evening)	Technical Exhibitors' Dinner
Wednesday, May 20, 1964	(morning)	Three Scientific Sessions
	(afternoon)	Three Scientific Sessions

1964 *Convention Schedule* . . . Approved the schedule, as proposed by the Annual Meeting Committee:

Tobacco Exhibits . . . Adopted the recommendation of the Annual Meeting Committee to discontinue exhibits by tobacco companies, beginning with the 1964 meeting.

Booth Rentals . . . Adopted the recommendation of the Annual Meeting Committee that the technical exhibits booth rental rate be increased from $30 per front foot to $5 per square foot, with 10 per cent extra for corner booths.

School Examination Law . . . Approved the action of the Council on Legislation not to reintroduce the school examination law until such time as positive action is taken on the medical and x-ray technicians' bill, S-138 of 1963.

Medical Examiners System . . . Approved the recommendation of the Council on Legislation to have representatives meet with the Attorney General of New Jersey and the Commissioner of Health, to improve the present system of investigating unusual deaths.

Reporting of Epilepsy . . . Approved the recommendation of the Council on Legislation that representatives meet with the Commissioner of Health to look into the matter of reporting of epilepsy by physicians.

Ophthalmic Technicians . . . Approved the contention of the Council on Legislation that the premise upon which Resolution No. 17 was based is false since, by law, a physician may only utilize those persons to assist him in the practice of medicine who are licensed under the Medical Practice Act (R.S. 45:9-21, paragraph k).

Current State Legislation . . . Adopted the positions on current state legislation, as indicated:

S-238 *Ozzard, Haines, Dumont—*
A-674 *Keith, Kijewski, Wegner, Maraziti*—To increase workmen's compensation benefits and to revise generally the State Workmen's Compensation Act. *Disapproval* . . . in consistency with the declared position of MSNJ in support of free choice of physician.

S-252 *Bowkley—*
A-700 *Gimson*—To amend the Workmen's compensation Law in several respects; increases maximum benefits to $50 weekly; increases the minimum to $15,000; increases death benefits to 450 weeks. *No Action*

S-284 *Farley*—To establish the pension contributions and benefits under Chapter 253, P.L. 1944, the police and firemen's retirement systems, to provide that a permanent and total disability resulting from a cardiovascular, pulmonary or musculo-skeletal condition which was not a direct result of a traumatic event occurring in the performance of duty shall be deemed a non-accident disability. *No action*

S-285 *Farley*—To establish the pension contributions and benefits under Chapter 255, P.L. 1944, the police and firemen's retirement system; and in the event of death, payments to beneficiaries; to provide that permanent and total disability resulting from cardio-vascular, pulmonary and musculo-skeletal conditions, which were not a direct result of a traumatic event occurring in the performance of duty, shall be deemed an ordinary disability, and to provide for the reduction of such retirement allowance in the event of subsequent earnings from employment; to provide for the election of trustees to the retirement system. *No action*

S-289 *Dumont, Waddington, Bowkley*—To correlate and consolidate the Act concerning the production, handling and distribution of milk, cream and milk products. *Approval*

S-291 *Farley*—To provide that any resulting dis-
S-292 *Farley*—ease of the respiratory system of a
S-293 *Farley*—member of a paid fire or police department shall be deemed an occupational disease. *Disapproval* . . . because they involve diagnosis by legislative enactment rather than by medical investigation.

A-441 *Sweeney, Farrington*—To repeal the law requiring migrant laborers to submit to examination for venereal diseases. *Disapproval* . . . because it regards the present law as salutary and desirable for the effective control of venereal disease among migrant workers.

A-489 *Meloni, Werner*—To amend the law providing for the licensing and regulation of hospitals and nursing homes to remove the restriction forbidding the Department of Institutions and Agencies to deny an application for license or approval on the sole ground that adequate hospital or nursing home facilities are already available in the area. *Approval*

A-737 *Meloni, Werner, Bigley*—To amend the act regulating nursing; reduces the age for professional nurse candidates from 20 years to 18 years and raises fees for examinations and registration. *Approval*

A-751 *Gross*—To empower the deputy Commissioner of Welfare to conduct research studies and related investigations to achieve savings in public welfare programs through rehabilitation of individuals. *Noted and filed.*

Good Samaritan Legislation . . . Noted that A-62 (to exempt licensed medical practitioners from civil action arising out of emergency care at the scene of an accident) was enacted into law: Chapter 140 of the Public Laws of 1963.

PR Projects for 1963-64 . . . Approved the following continuing projects, carried out under the auspices of the Council on Public Relations:

(1) Publication and distribution of:
   a. *Junior Health Hints* to schools and public libraries.
   b. *Health Hints* to the press, house organs, and other media, over the signature of "Michael S. Newjohn, M.D."
   c. *Membership News Letter,* including the annual compilation of a bound, indexed set to component societies.
   d. *Periodic Newsletter* to cooperating agencies and individuals.
(2) Preparation and publication of special news releases and publicity as required from time to time in furtherance of the Society's business and interests, including:
   a. 1963 Eye Health Screening Program.
   b. 1964 Annual Meeting.
(3) Responsibility for the bestowal of the Golden Merit Award.
(4) Responsibility for the press room at the Annual Meeting.
(5) Maintenance of press clipping service for the Society's public relations features, releases, and press notices.
(6) Continuance of consultative service in support of the public relations activities of component societies.
(7) Encouragement of indoctrination program under the sponsorship of the component societies.
(8) Preparation and distribution of a membership service kit.

Membership Directory . . . Adopted the recommendation of the Council on Public Relations that a special supplement of approximately 20 pages (40 sides) be inserted as part of the 1964 and each subsequent *Directory* mailed to members of MSNJ containing at least the following: Constitution and Bylaws, Principles of Medical Ethics, Legal Hazards of Medical Practice, Poison Control Centers.

. . . Also adopted the recommendation of the Council on Public Relations that this supplement be *not* inserted in those copies planned for sale to non-members.

Repayment of Student Loans . . . Adopted the following recommendation of the Committee on Medical Student Loan Fund:

> The maximum amount to be available annually to any borrower shall be $1,000, repayable by four equal installments quarter-annually beginning two years after the commencement of the practice of medicine. In the event that more than one such loan is made, repayment of the same, upon the above terms, shall be made consecutively and not concurrently. Interest of 3 per cent will be charged on the unpaid balance from the date of the borrower's entrance into medical practice.

Health Mobilization Training Course . . . Agreed that MSNJ co-sponsor the course, to be held on February 18-19 (1964) in Newark under the auspices of the State Department of Health in cooperation with the United States Public Health Service.

Vendor Voucher Forms . . . Approved the following requests of the Division of Welfare:

(1) That the physician's New Jersey license number be noted on the prescription form for a welfare patient; and
(2) That the prescribing physician who telephones a prescription for a welfare patient to the pharmacist himself—or through the patient—deliver the written prescription to the pharmacist before it can be filled.

Classified Advertising . . . Approved the following recommendation of the Publication Committee:

That—effective January 1, 1964—it shall be the policy of THE JOURNAL to restrict the use of classified advertisements to professional personnel (seeking professional associates or assistants, offering practices or equipment for sale, or announcing the availability to the profession of specialty services), to physicians seeking to locate in New Jersey, or to widows of physicians desirous of disposing of the property or professional equipment of their late husbands.

AMA Clinical Meeting . . . Authorized the following to attend the meeting in Portland, Oregon, December 1 - 4, with expenses paid: President, President-Elect, Executive Director, and Dr. Frank J. Hughes, of Camden, alternate, who will serve as the 6th delegate in place of Dr. Marcus Greifinger.

SPECIAL AND LIAISON REPRESENTATIVES, AND SPECIAL COMMITTEES 1963 - 64

Aged, New Jersey Joint Council to Improve the Health Care of the

David Eckstein, M.D., Chairman, Trenton
Matthew E. Boylan, M.D., Jersey City
John F. Kustrup, M.D., Trenton
John B. Fuhrmann, M.D., Flemington
Equal representation from:
New Jersey Hospital Association
New Jersey State Dental Society
New Jersey State Nurses' Association
Licensed Nursing Homes of New Jersey, Inc.

Air Pollution, Advisory Committee to Commission on (Subcommittee of Council on Public Health)

Richard B. Berlin, M.D., Chairman, Teaneck
John P. Coughlin, M.D., Jersey City
Estelle T. Milliser, M.D., Westfield
Frank L. Rosen, M.D., Consultant, Maplewood

American Medical Association—Education Research Foundation, N. J. Chairman

Chairman, Medical Student Loan Fund Committee (Luke A. Mulligan, M.D., Leonia)

Audit Committee (1962-63 Audit)

Frank J. Hughes, M.D., Chairman, Gloucester
Samuel J. Lloyd, M.D., Trenton
Thomas C. DeCecio, M.D., Cliffside Park
Consultants:
Treasurer (Daniel F. Featherston, M.D., Asbury Park)
Chairman, Committee on Finance and Budget (Carl N. Ware, M.D., Ocean City)

Bicentennial History (1966)

Fred B. Rogers, M.D., Trenton

Blood Bank Commission of New Jersey

Authorized agent of Medical Society in approved Blood Bank Programs

Blood Bank Commission Representatives

John J. Torppey, M.D., Newark
Jerome G. Kaufman, M.D., Maplewood

Blue Cross and Blue Shield Plans of New Jersey, Permanent Committee on

Chairman, Board of Trustees (Samuel J. Lloyd, M.D., Trenton)
President (Jerome G. Kaufman, M.D., Maplewood)
Executive Director (Mr. Richard I. Nevin, Trenton
Equal representation from:
Medical-Surgical Plan of New Jersey
Hospital Service Plan of New Jersey
New Jersey Hospital Association

Board of Control, State Department of Institutions and Agencies (appointed by Governor—term, 8 years)

Frank J. Hughes, M.D., Gloucester (June 1971)

Bureau of Investigation, State Department of Law and Public Safety, Cooperating Committee With

Board of Trustees

Chamber of Commerce Legislative Conference

Executive Director (Mr. Richard I. Nevin, Trenton)

Chronic Sick, State Advisory Council (appointed by Governor—term, 3 years)

William D. Kimler, M.D., Haddon Heights (December 1963)

Civil Defense Organization, Liaison with State

Chairman, Committee on Disaster Medical Care (Jack R. Karel, M.D., Hillside)

Convulsive Disorders, Advisory Council to New Jersey Consultation Service For

Chairman, Committee on Mental Health (Robert S. Garber, M.D., Belle Mead)

Crippled Children and Adults, New Jersey Society for (Statewide Sponsoring Committee)

President (Jerome G. Kaufman, M.D., Maplewood)

Crippled Children Commission, State (appointed by Governor—term, 5 years)

Frederick G. Dilger, M.D., Hackensack (May 1966)

Diabetes Detection Drive—Liaison Representative

John J. Torppey, M.D., Newark

Disaster Control, Joint Committee with Hospital Association

Special Committee on Disaster Medical Care

Disputed Claims, Advisory Committee to Review MSP and HSP

1st District—F. Clyde Bowers, M.D., Chairman, Mendham
Ralph M. L. Buchanan, M.D., Phillipsburg
2nd District—John J. Bedrick, M.D., Bayonne
Robert A. Cosgrove, M.D., Jersey City
3rd District—Gerard R. Gessner, M.D., Vice-Chairman, New Brunswick
John A. Kinczel, M.D., Trenton
4th District—Reuben L. Sharp, M.D., Camden
John C. Clark, M.D., Asbury Park
5th District—Nicholas E. Marchione, M.D., Vineland
Louis K. Collins, M.D., Glassboro
(Quorum: 4 members)

Dual County Practice, Special Committee on

John J. Bedrick, M.D., Bayonne
Thomas C. DeCecio, M.D., Cliffside Park

Education, Liaison with State Department of

Chairman, Special Committee on Child Health (Robert E. Jennings, M.D., South Orange)

Emotionally Disturbed Child, Advisory Council to State Department of Education (appointed annually by Commissioner of Education)

Jesse McCall, M.D., Newton (September 1963)

Epilepsy, Advisory Panel to Director of Motor Vehicles

Chairman, Special Committee on Mental Health (Robert S. Garber, M.D., Belle Mead)

Executive Committee (Bylaws, Chapter IV, Section 5 b.)

President (Jerome G. Kaufman, M.D., Maplewood)
President-Elect (Charles H. Calvin, M.D., Perth Amboy)
First Vice-President (John J. Bedrick, M.D., Bayonne)
Second Vice-President (Joseph R. Jehl, M.D., Clifton)
Chairman, Board of Trustees (Samuel J. Lloyd, M.D., Trenton)

Fluoridation, Joint Committee on

John B. Fuhrmann, M.D., Flemington
Edwin H. Albano, M.D., East Orange
Equal representation from:
State Department of Health
New Jersey State Dental Society

Health Insurance Conference

Daniel F. Featherston, M.D., Chairman, Asbury Park
Marcus H. Greifinger, M.D., Newark
Royal A. Schaaf, M.D., Califon
President (Jerome G. Kaufman, M.D., Maplewood)
President-Elect (Charles H. Calvin, M.D., Perth Amboy)
First Vice-President (John J. Bedrick, M.D., Bayonne)
Second Vice-President (Joseph R. Jehl, M.D., Clifton)
Executive Director (Mr. Richard I. Nevin, Trenton)
Equal representation from:
Health Insurance Council

Health, Liaison with State Department of

Chairman, Council on Public Health (John B. Fuhrmann, M.D., Flemington)

Hospital Advisory Council, State Department of Institutions and Agencies (appointed by Board of Control—term, 4 years)

C. Byron Blaisdell, M.D., Asbury Park (December 1963)
Luke A. Mulligan, M.D., Leonia (December 1965)

Hospital Service Plan Board of Trustees (per Hospital Service Plan of New Jersey Bylaws)

President (Jerome G. Kaufman, M.D., Maplewood)

House Maintenance, Staff Policies, and Personnel Relations, Special Committee on

President (Jerome G. Kaufman, M.D., Maplewood)
President-Elect (Charles H. Calvin, M.D., Perth Amboy)
Chairman, Board of Trustees (Samuel J. Lloyd, M.D., Trenton)
Chairman, Committee on Finance and Budget (Carl N. Ware, M.D., Ocean City)
Secretary (Marcus H. Greifinger, M.D., Newark)
Treasurer (Daniel F. Featherston, M.D., Asbury Park)
Chairman, Former House Committee (L. Samuel Sica, M.D., Trenton)
Executive Director (Mr. Richard I. Nevin, Trenton)
Consultant (William T. R. Cox, M.D., Elizabeth)

Institutions and Agencies, Liaison with State Department of

Frank J. Hughes, M.D., Gloucester

Intra-Hospital Infections, Joint Committee on

Edwin H. Albano, M.D., Chairman, East Orange
Lawrence Gilbert, M.D., Newark
Thomas K. Rathmell, M.D., Trenton
Eugene H. Kain, M.D., Camden
Equal representation from:
State Department of Health
New Jersey Hospital Association
New Jersey State Nurses' Association

Lay Health Organizations and Paramedical Groups, Official Intermediaries with

Members of the Council on Public Health as assigned by the chairman.
(assignment of official intermediaries from The Medical Society of New Jersey to lay health organizations and/or paramedical groups does not imply endorsement of the organization/group or its program)

Legislation, Federal Keymen

14 Congressional District Keymen

Legislation, State Keymen

21 County Keymen

Medical Assistants, New Jersey Association of

Joseph R. Jehl, M.D., Clifton

Medical-Hospital-Nursing Conference (Tri-partite)

President (Jerome G. Kaufman, M.D., Maplewood)
President-Elect (Charles H. Calvin, M.D., Perth Amboy)
Immediate Past-President (Louis S. Wegryn, M.D., Elizabeth)
Executive Director, Ex-Officio (Mr. Richard I. Nevin, Trenton)
Equal representation from:
New Jersey Hospital Association
New Jersey State Nurses' Association

Medical-Legal Testimony, Special Committee on

Marcus H. Greifinger, M.D., Chairman, Newark
Joseph P. Donnelly, M.D., Jersey City
Louis S. Wegryn, M.D., Elizabeth
Daniel F. Featherston, M.D., Asbury Park
Samuel J. Lloyd, M.D., Trenton
Jerome G. Kaufman, M.D., Ex-Officio, Maplewood
Mr. Robert M. Backes, Ex-Officio, Trenton

Medical Liaison Committees (Dental, Legal, Hospital, Nursing, Osteopathic, and Pharmaceutical)

President (Jerome G. Kaufman, M.D., Maplewood)
President-Elect (Charles H. Calvin, M.D., Perth Amboy)
Immediate Past-President (Louis S. Wegryn, M.D., Elizabeth)
Executive Director, Ex-Officio (Mr. Richard I. Nevin, Trenton)
(Where number of representatives from other organization is larger than number of Medical Society representatives, the latter will be increased from the Presidential Officers to equal the former.)

MSNJ-MSP Boards of Trustees, Liaison Committee of

Nicholas A. Bertha, M.D., Wharton
Frank J. Hughes, M.D., Gloucester
Louis S. Wegryn, M.D., Elizabeth
Mr. Richard I. Nevin, Ex-Officio, Trenton
Equal representation from:
Medical-Surgical Plan Board of Trustees

Medical-Surgical Plan Board of Trustees (per Medical-Surgical Plan Bylaws)

President (Jerome G. Kaufman, M.D., Maplewood)

Medicare Fiscal Agent

Medical Service Administration of New Jersey

Medicare Program, Special Committee on

Carl N. Ware, M.D., Chairman, Ocean City
Nicholas A. Bertha, M.D., Wharton
Joseph R. Jehl, M.D., Clifton
L. Samuel Sica, M.D., Trenton

Membership Directory, Special Committee on

Marcus H. Greifinger, M.D., Chairman, Newark
Louis S. Wegryn, M.D., Elizabeth
John J. Bedrick, M.D., Bayonne
Nicholas A. Bertha, M.D., Wharton
George B. Sharbaugh, M.D., Trenton
Mr. Richard I. Nevin, Executive Director, Ex-Officio, Trenton
Mr. Robert H. Lambert, Office Manager, Ex-Officio, Trenton

Motor Vehicles, Liaison with State Division of

Chairman, Special Committee on Traffic Safety (William L. Sprout, M.D., Salem)

Neurologic Program Steering Committee to New Jersey Consultation Service for Convulsive Disorders

J. Lloyd Morrow, M.D., Passaic

Nursing Education and Recruitment, Permanent Committee on

Jesse McCall, M.D., Chairman, Newton
Irving M. Levitas, M.D., Westwood
William P. Mulford, M.D., Beverly
Lewis E. Savel, M.D., South Orange
Equal representation from:
New Jersey Hospital Association
New Jersey League for Nurses
New Jersey State Nurses' Association
Administrators of Nursing Schools
2 Advisors from State Department of Education

Nutrition Council, New Jersey—Liaison With

S. William Kalb, M.D., Newark

Osteopathic Question, Special Committee on

Emanuel M. Satulsky, M.D., Elizabeth
Louis K. Collins, M.D., Glassboro
John J. Bedrick, M.D., Bayonne

Pension Plan, Special Committee on

Chairman, Committee on Finance and Budget (Carl N. Ware, M.D., Ocean City)
Chairman, Special Committee on House Maintenance, etc., (Jerome G. Kaufman, M.D., Maplewood)
Treasurer (Daniel F. Featherston, M.D., Asbury Park)

Physician-Hospital Relationships (Subcommittee of Council on Medical Services)

Francis J. Benz, M.D., Chairman, Chatham
Durant K. Charleroy, M.D., Lawrenceville
Nicholas E. Marchione, M.D., Vineland
Joseph M. Gannon, M.D., Plainfield
Andrew C. Ruoff, III, M.D., Pompton Plains
Louis S. Wegryn, M.D., Consultant, Elizabeth
Frank J. DiTraglia, M.D., Consultant, Morris Plains
Mr. Robert M. Backes, Counsel, Consultant, Trenton

Public Health Association, New Jersey

Louis S. Wegryn, M.D., Elizabeth (Delegate)
Mr. Richard I. Nevin, Trenton (Alternate)

Publication Committee, Trustee Members to Augment

Daniel F. Featherston, M.D., Asbury Park
Joseph R. Jehl, M.D., Clifton
Frank J. Hughes, M.D., Gloucester
Samuel J. Lloyd, M.D., Ex-Officio, Trenton

Radiation Protection Commission, Consultant to New Jersey

Louis J. Levinson, M.D., Newark

Safety Council, New Jersey State (per Council By-laws)

President (Jerome G. Kaufman, M.D., Maplewood)
President's representative, A. M. K. Maldeis, M.D., Camden

Selective Service System, Chairman of New Jersey Advisory Committee (appointed by National Advisory Committee)

Jesse McCall, M.D., Newton

Seton Hall Chapter of Student AMA—Liaison with

Joseph P. Donnelly, M.D., Jersey City

Tuberculosis Council—Liaison with State

John B. Fuhrmann, M.D., Flemington

Utilization of Available Nurses, State Advisory Committee to Study

Chairman, Permanent Committee on Nursing Education and Recruitment (Jesse McCall, M.D., Newton)

Widows and Orphans of Medical Men of New Jersey, Society for Relief of—Liaison with

Joseph R. Jehl, M.D., Clifton

Announcements • • •

Neurology and Psychiatry Symposium

Wednesday, November 20, at 2 p.m. has been set aside for the annual neurology-psychiatry symposium of the V.A Hospital in East Orange. Topics and speakers are:

2 p.m. Treatment of Parkinson's Disease. R. S. Schwab, M.D., Boston.

3 p.m. Evolution of Structure and Function in Emotional and Neurologic Disorders. A. M. Rabiner, M.D., Albany.

You are welcome. The meeting will be on the third floor of the Hospital which is at Centre and Tremont Streets in East Orange.

Pathology Slide Seminar

For the 13th consecutive year, the New Jersey Society of Pathologists joins our State Health Department in sponsoring a slide seminar. This year it will be at the Essex House, Lincoln Park, Newark, starting at 2 p.m., Saturday, December 14. The moderator, Dr. E. B. Helwig, is director of dermatology at the Armed Forces Institute of Pathology. This year's seminar will focus on dermatologic lesions. An exceptional series of slides and case histories has been accumulated. You are invited to attend.

Colitis Film Available

Pharmacia Laboratories of 501 Fifth Avenue, New York 17, New York, has available a 16 mm. color-sound film on colitis. The running time is 31 minutes and the film shows endoscopic views of ulcerative colitis with particular emphasis on its diagnosis, pathology, complications, and treatment. The film is available without charge if shown to medical audiences. If interested, write to the Pharmacia Laboratories at the above address.

Course in the Economics of National Security

A correspondence course in the economics of national security is now available. Many physicians meet the eligibility criteria. To find out if you are eligible, write to Industrial College of the Armed Forces, Correspondence Branch, at Fort Lesley McNair, Washington 25, D. C.

The course deals with all segments of the Nation's economy—its human and natural resources and the capability and potential of its production and service industries—including policies, methods, procedures and problems incident to using the economy in the maintenance of national security. The course is organized into five units with coverage as follows:

Unit I, Introduction -- Background.

Unit II, Resources and Facilities.

Unit III, Processes in the Economics of National Security.

Unit IV, Foreign Relations.

Unit V, Problems of National Security — The problems in using the national economy in support of national security — the administration of the nation's economy, stabilization of the economy, reconversion, partial mobilization and evaluation of experiences.

Enrollment for the entire course is desirable but not required. Qualified individuals may enroll for any one or more of the five units.

A certificate of completion is given to each student successfully completing the course.

Merged Health Posts in Atlantic County

The Freeholders of Atlantic County and the Mayor of Atlantic City have announced that Dr. Max Gross of Ventnor will be appointed to the two positions of County Health Coordinator and City Public Health Officer. Formerly with the State Health Department, Dr. Gross was characterized by Mayor Altman as one of a very small group of doctors qualified to hold both positions.

ACCP Fellowships in New Jersey

The American College of Chest Physicians announces the conferring of Fellowship on the following New Jersey practitioners:

Maxwell Borow, Bound Brook
Edmon B. Lee, Cranford
G. Barton Barlow, Englewood
Joseph W. Bitsack, Hackensack
William A. Halbeisen, Haddonfield
Alexander J. Povalski, Jersey City
Calvin E. Oyer, Kearny
Dryden P. Morse, Moorestown
Edward B. Tyson, Ocean City
William F. Haynes, Princeton
S. J. Tsai, Verona

Obituaries • • •

DR. GEORGE M. BROOKS

One of sourthern New Jersey's leading citizens passed away on September 14, 1963, with the death that day of Dr. George M. Brooks. A 1918 graduate of the Jefferson Medical College, Dr. Brooks interned in North Carolina in 1919 and 1920. After general practice in that state, he came north in 1930 and settled in Cape May County. He has thus been serving the people of that part of New Jersey for more than three decades. He was vice-president of his county medical society and was active in committee work there. He was on the staffs of both the Shore Memorial and the Tomlin Memorial Hospital. He was medical advisor to the Selective Board during World War II, and for a quarter of a century served as Middle Township school physician.

DR. HERMAN GOLDMACHER

At the untimely age of 58, Dr. Herman Goldmacher of Elizabeth died at his home on August 10. A board-certified otolaryngologist, Dr. Goldmacher was the attending surgeon in that service at Alexian Brothers Hospital. He lived in New York City during his childhood and received his M.D. at Bellevue in 1928. After a brief period of general practice in New York City, he accepted an otolaryngologic residency at Alexian Brothers Hospital in Elizabeth and thereafter remained affiliated with that hospital through the rest of his professional life. He received his American Board diploma in otolaryngology in 1942. Dr. Goldmacher was a consultant in his specialty at several other hospitals in the New York City area.

DR. LESTER GRADDICK

A former president of the Morristown Board of Health and a past president of the Morris County Urban League, Dr. Graddick died suddenly on September 17, 1963. Dr. Graddick, who was born in 1900, received his M.D. at Howard in 1925. After interning at the Friedman's Hospital in Washington, D. C., he came to New Jersey where he entered on the private practice of medicine in Morristown. He was one of the founders of the Morris County Urban League, serving as a Trustee or officer almost continuously since 1934. He was Associate Attending Physician at the All Souls Hospital in Morristown.

DR. G. LEONARD JOHNSON

Dr. G. Leonard Johnson, one of Bergen County's pioneer pediatricians, died in Charlottesville, Virginia, on September 26, 1963. Born in 1901, he received his baccalaureate degree at Princeton in 1923. In 1927, Columbia University awarded him his M.D. at the College of Physicians and Surgeons there. He did graduate work in pediatrics in England, and he then came to Bergen County, New Jersey to practice that specialty. Dr. Johnson was, for many years, school physician in Englewood. During World War II, he was chief of internal medicine in an Army Hospital in the European theatre. Dr. Johnson was chief, later consultant in pediatrics at the Englewood Hospital. He was a diplomate of the American Board of Pediatrics, and a civic leader in child care activities throughout New Jersey.

DR. OLIVER K. PARRY

Monmouth County lost one of its civic leaders and New Jersey medicine one of its most active members when Dr. Oliver K. Parry died on August 14, 1963. Born in Utah in 1893, Dr. Parry received his degree at Bellevue in 1920. He then came to Monmouth County, New Jersey and had been serving the people of our shore area ever since. Dr. Parry was active in many civic affairs, and had several tours of duty as a councilman for Asbury Park. He was also a Trustee of the National Bank there. Dr. Parry has been president of the Monmouth County Medical Society. He was a Fellow of the American College of Surgeons and, for several years, was director of surgery at Fitkin Memorial Hospital.

DR. EUGENE ROBBINS

One of the state's leaders in industrial medicine, Dr. Eugene Robbins died of a heart attack at his home in Millburn on August 6, 1963. Born in 1902, he attended the University of Alabama and then went to medical school of the University of Illinois from which he was graduated in 1928. He did general practice in Newark, and served the New Jersey Manufacturers Association Hospital in Jersey City for many years, eventually becoming chief of staff there. He was also an adjunct orthopedist at St. Francis Hospital in Jersey City, and was affiliated with many other hospitals in the Essex-Hudson area. He was an elder of the Wyoming Presbyterian Church in Millburn.

Book Reviews • • •

Pediatric Diagnosis. Morris Green, M.D. and Julius B. Richmond, M.D. Philadelphia, 1962, W. B. Saunders Co. Pp. 541. Ed. 2. ($13.00)

This is an excellent review for examination and diagnosis in pediatrics. If one were to use it in preparation for the American Board Examinations, it would be of real help, read from beginning to end. The section on *physical examination* covers the entire body with a description of abnormalities found in each area. The author then tabulates *Signs and Symptoms* with the same organized thoroughness. There are many "lists" which simply number the conditions that may show such sign or symptom. There are frequent references for one who may wish to look up further details. These are conveniently placed midway in the paragraph of interest and not at the end where they might be neglected.

The final portion is devoted to *Health Supervision*—emphasizing its importance in pediatrics. This is taken up chronologically from infant to adolescent.

The index is one of the best. The authors have certainly made a valiant effort to cross index as adequately as possible; and this is essential to the successful use of such a book, since one item may be discussed in each section.

As a review, books of this type are fine. But for the average practicing pediatrician they can be frustrating. Used to look up severe problems or as preparation for case presentation, they don't go into enough detail; and other sources must be used anyway.

In any case, it is an excellent review.

PHOEBE HUDSON, M.D.

The Reluctant Surgeon: A Biography of John Hunter, Medical Genius and Great Inquirer of Johnson's England. By John Kobler. Garden City, New York, 1962, Doubleday Dolphin Book (Paper Back). Pp. 439. ($1.45)

This fine biography of Dr. John Hunter (1728-1793), now issued in inexpensive paper back form, provides an accurate and readable account of the life, labors, and times of the dour Scot who was, in the words on his memorial in Westminster Abbey, "the founder of scientific surgery." Surgeon to King George III, naturalist, experimenter, and collector, Hunter lived in a fascinating age—and was a bright ornament of the period. An unusual medical genius, his industry did much to turn surgery and pathology into sciences. In this book, *Saturday Evening Post* contributing editor John Kobler achieves his stated goal: "to reclaim the scientist from the archives and the man from the shadows."

John Hunter and his older brother, William, both skilled anatomists, were pioneers in study of the circulation, lymphatics, generation, and parturition. Experimental surgery owes much to John Hunter for his methodical research on inflammation, repair, and tissue transplants. His achievements in biology, comparative anatomy, dentistry, hematology, and urology, ranged far and wide in scope. Students and disciples of "the dear man" included is presented in outline fashion. The author again smallpox; John Morgan—founder of North America's first medical school, and his Philadelphia colleague, William Shippen, Jr.; Philip Syng Physick—the "father of American Surgery"; and Benjamin Waterhouse—Harvard professor and early vaccinator in the United States. (Through the office of his friend Benjamin Franklin, John Hunter was elected a member of the American Philosophical Society in 1787.) Samuel Johnson's biographer, James Boswell, was a patient of Hunter's, as was the child Lord Byron, for whom the doctor prescribed an orthopedic shoe that allowed him to walk.

John Hunter's brilliant contributions to medicine, his turbulent life, colorful personality, and the eighteenth-century setting in which he prospered are all deftly recreated in this biography. Although lacking illustrations, the volume has adequate notes, a detailed bibliography, and an index. It is highly recommended to all who would know more about an heroic figure in the history of medicine.

FRED B. ROGERS, M.D.

Handbook of Pharmacology. Windsor C. Cutting, M.D. New York, 1962, Appleton-Century-Crofts. Pp. 643 (soft cover). ($5.95)

The increasing use of soft-bound medical books has apparently made it possible to offer fresh volumes at modest prices. This handbook is an example. It consists of 61 chapters arranged by drug action groups (tranquilizers, anesthetics, diuretics, ganglionic agents, and so on). The subject material is presented in outline fashion. The author attains compactness at the cost of some jerkiness of style. The material is all there, presented in somewhat pedestrian fashion. The book is crowded with structural formulas which say little to the average clinician. This is a good reference volume, though its stark outline form may somewhat reduce its usefulness.

VICTOR HUBERMAN, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

NOVEMBER, 1963 • VOL. XXXVI, NO. 9

MANAGEMENT OF SPONTANEOUS PNEUMOTHORAX

Differences of opinion on the management of spontaneous pneumothorax led a group at the Mayo Clinic to review the cases treated there over a 12-year period. For first attacks surgery did not appear indicated, but was frequently advisable for recurrent episodes.

Because of lack of agreement concerning the proper treatment of spontaneous pneumothorax, it was decided to review the records of the cases with this condition diagnosed during the years 1945 through 1956 at the Mayo Clinic.

Excluded from the study were all cases caused by accidental trauma or by thoracic operations and those related to obvious intrapulmonary disease such as lung abscess with perforation into the pleural space. Patients with a pneumothorax produced intentionally for diagnostic or therapeutic purposes also were excluded.

Data abstracted from each record included history of previous episodes of pneumothorax and of chronic pulmonary disease, the activity of the patient at the time of onset of the pneumothorax, and the symptoms of the attack which prompted the patient to seek medical care at the Clinic.

Roentgenograms of the thorax were reviewed to determine the degree of collapse of the affected lung, the presence of pulmonary disease, and the occurrence of pleural effusion. Data were also obtained regarding the treatment of the patient and the results of treatment.

Of 157 cases included in the investigation, 109 had come to the Clinic during their first episode of spontaneous pneumothorax; the remaining 48 had had two or more attacks. There were 32 women in the series and 125 men.

Of the 109 cases of initial attack, 58 were on the right side, 47 on the left, and 4 were bilateral. Of the 48 recurrences, 26 were on the right, 19 on the left, and 3 were bilateral. All of the attacks had occurred on the same side in 31 of the recurrent cases; on the contralateral side in 8; and on both sides in 9 but not simultaneously in all cases. Three of the 48 had had more than five previous episodes of pneumothorax.

LITTLE CHRONIC RD

Association of spontaneous pneumothorax with chronic respiratory disease was not common in the patients, there being no history of such in 85 (78 per cent) of those with original attacks and 42 (87 per cent) of those with recurrent attacks. Asthma or chronic bronchitis and emphysema were the most prevalent chronic pulmonary diseases among the rest of the group. There was no evidence that collapse of the lung was precipitated by any particular exertion. The most common symptoms were dyspnea, pain in the chest, and cough. Some had no symptoms at all and the pneumothorax was discovered when a roentgenogram of the thorax was made for other reasons.

Since treatment was not initiated for all of

David T. Carr, M.D.; Arthur W. Silver, M.D.; and F. Henry Ellis, Jr., M.D., *Proceedings of the Staff Meetings of the Mayo Clinic,* March 13, 1963.

the patients while they were under our care, the data on therapy do not include all patients. Some patients, however, had more than one form of treatment. Forty patients with initial attacks and eight with recurrent attacks were treated by rest. In 43 the lung reexpanded satisfactorily but the other five required more vigorous treatment. Pneumothorax recurred in only 6 cases during an average follow up period of 7½ years.

AIR AND FLUID ASPIRATED

Fifty-four patients with initial attacks and 25 with recurrent attacks were treated by insertion of an intercostal cannula or catheter and prolonged aspiration of air and fluid from the pleural space. In 55 the lung reexpanded satisfactorily. Thirty-nine had no further troubles during an average follow up period of more than 5 years.

Surgical treatment by thoracotomy was advised and performed for six of the 109 patients with an original pneumothorax. This treatment was chosen because of apparent pleural or pulmonary disease or because of the duration of the pneumothorax prior to consultation at the Clinic. The surgeon found that three of these patients had emphysematous blebs. One patient had only a pleural exudate and the other two had no demonstrable abnormality. The surgical procedure depended on the disease that was detected. The blebs were resected, the pleura decorticated or simply abraded and, in one case, a parietal pleurectomy was performed. All patients had good results, none having another pneumothorax during an average follow-up of 5 years.

Good results were also obtained by surgical treatment of 40 patients whose pneumothoraces were recurrent. Subpleural blebs were detected in 26 of these. The surgical procedure varied from simple abrasion of the pleura or application of talc to the pleura to cause adhesions to actual parietal pleurectomy, the last operation being carried out in 14 cases. Lung tissue was resected when this seemed advisable. A simple wedge resection was adequate in most cases but a lobectomy was needed in six and the entire lung was removed in two. None of these patients had a recurrence on the ipsilateral side during the follow-up period, which averaged 4.4 years. However, five had spontaneous pneumothorax on the contralateral side between 10 days and 5 years later.

Follow up revealed that 21 of the 157 patients had died. Fourteen of these deaths were unrelated to the pneumothorax. In seven there might have been a significant relationship.

COMMENT

Since this was not a controlled study the results of one group cannot be compared with those of the other to determine which is the better treatment for general use. However, the data can be used to evaluate, in a broad sense, the management of patients with spontaneous pneumothorax.

While the success of the simpler modes of therapy, particularly for patients with an initial pneumothorax, is a potent argument against the routine use of the more radical surgical treatment, simple rest or continuous aspiration of air from the pleural space is not adequate treatment for all patients.

NEW JERSEY TUBERCULOSIS AND HEALTH ASSOCIATION
15 EAST KINNEY STREET, NEWARK 2, NEW JERSEY



in visceral motor disorders...

EASIER MANAGEMENT

When emotional disturbance is a significant factor in dysfunction of gastrointestinal tone, motility and secretion, Pro-Banthīne with Phenobarbital provides the dual activity that leads to easier management of both the patient and his problem:

Pro-Banthīne (propantheline bromide) to neutralize the effect of excitatory impulses at visceral end organs, *and*

Phenobarbital to moderate emotional incitement centrally.

Pro-Banthīne with Phenobarbital is indicated when a mild to a moderate psychic element is a factor in: Peptic ulcer • Biliary dyskinesia • Pylorospasm • Intestinal hypermotility • Spastic colon • Gastritis • Other dysfunctions of the gastrointestinal tract.

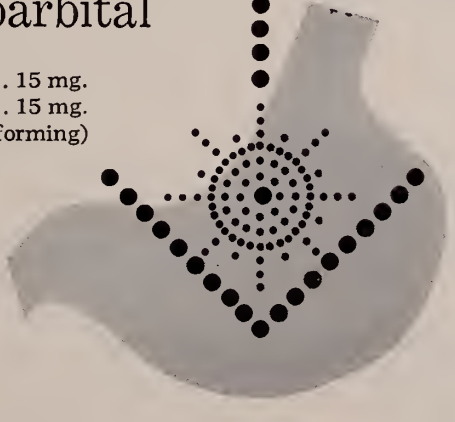
Dosage: One tablet four times a day.

Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action might occur with Pro-Banthīne (brand of propantheline bromide). It is contraindicated in the presence of glaucoma or severe cardiac disease. The usual precautions with regard to phenobarbital should be taken.

G. D. SEARLE & CO.
CHICAGO 80, ILLINOIS
Research in the Service of Medicine

PRO-BANTHĪNE®
with Phenobarbital

Each tablet contains:
propantheline bromide .. 15 mg.
phenobarbital ..... 15 mg.
(Warning: May be habit forming)



reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem. KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.



KOAGAMIN®

parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenol 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

CHATHAM PHARMACEUTICALS, INC.
Newark 2, New Jersey
Distributed in Canada by Austin Laboratories, Ltd. • Paris, Ontario

DUGAN'S

"Bakers for the Home"

New - LITE DIET BREAD

(White Bread Baked Without Shortening)
Calories per Slice 42 Calories per oz. 70

ALSO

SALT-FREE BREAD
GLUTEN AND PROTEIN BREADS
100% WHOLE WHEAT
100% Whole Wheat Crackers

New York New Jersey
Connecticut Pennsylvania

"At Your Door or To Your Store
It's DUGAN'S for BETTER Baked Goods"

Phone for Delivery

HUmboldt 2-6007 in Newark

(or your local phone book for branch nearest you)

NEW YORK FERTILITY INSTITUTE

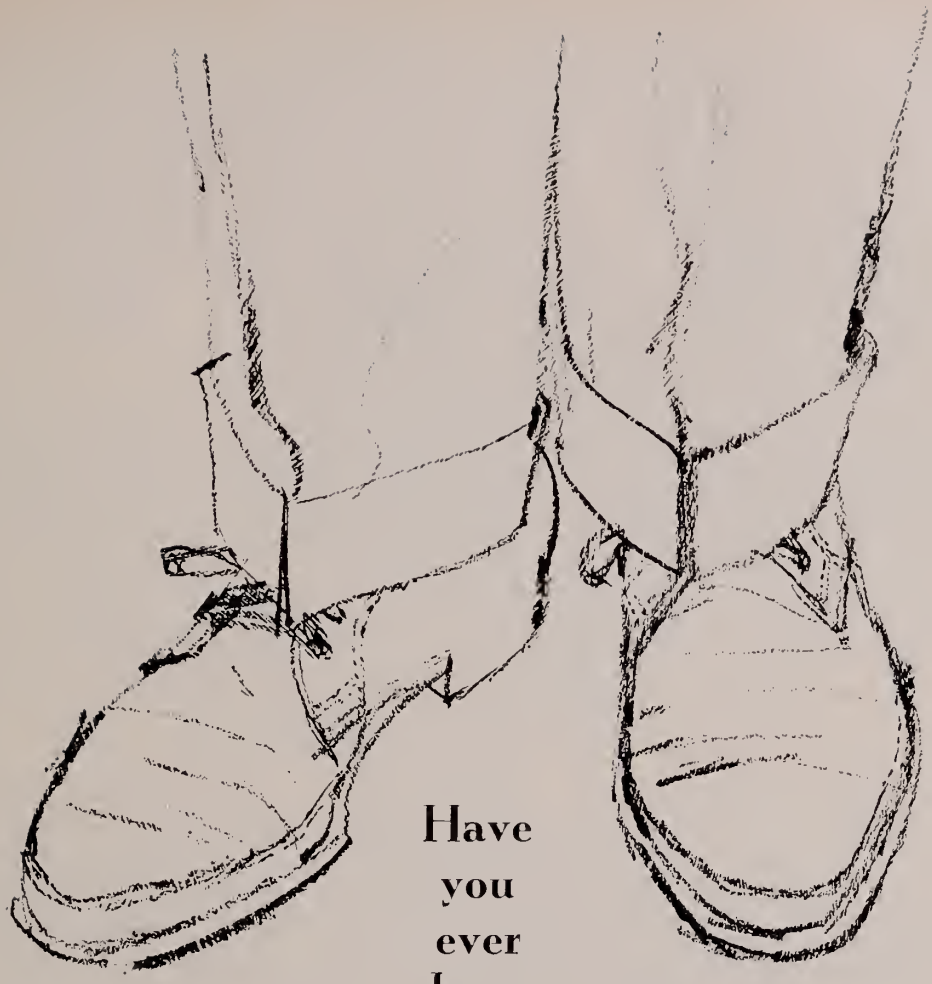
For the Investigation of Problems of Human Infertility

The Institute provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

Patients are accepted by the Institute only by doctor referral and returned to the referring physician after appropriate studies have been made, together with a complete detailed report of the findings of the Institute and its consultants and recommendations for therapy. Literature on request.

123 East 89th Street, N. Y. 28, N. Y.

Phone: TR 6-9300



Have you ever been in the patient's shoes?

Doctors are quite familiar with the services rendered by New Jersey Blue Shield from the physician's point of view. But what happens when the shoe is on the other foot?

A pediatrician in South Jersey* recently had a chance to find out. Here is what he has to say in a letter sent to Blue Shield:

"I want to thank you all for the very fine financial aid you gave me in my recent disability. It was a real life-saver. Shall sing your praises always."

While you may never have to look to Blue Shield for services as a patient, here is excellent testimony from a colleague as to the help the Plan offers to its subscribers in time of need.

* Name of physician available on request.

BLUE SHIELD®
MEDICAL-SURGICAL PLAN OF NEW JERSEY
500 Broad Street, Newark

BRUNSWICK PARK NURSING HOME

NEW JERSEY'S NEWEST, MOST MODERN HOME FOR THE CONVALESCENT, CHRONICALLY ILL AND AGED



NOW OPEN!

NO STEPS TO CLIMB!

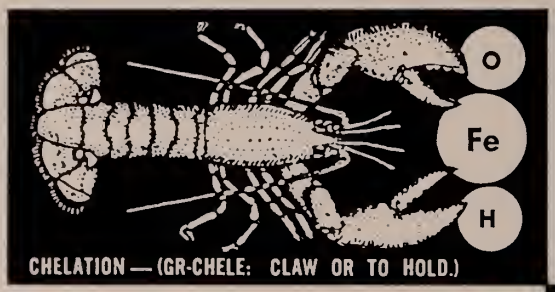
REASONABLE RATES

INSPECTION INVITED

- Referring physicians have full medical privileges
- Physical and recreational therapy program
- Experienced professional staff
- Special diets
- Complete 24-hour general nursing care
- Audio-Visual Nurses' call system for every bed
- Air-conditioned
- Private & semi-private rooms
- Sanitary all-stainless steel kitchen, tiled to ceiling
- Tiled wheel-in showers and baths
- Piped-In music
- Spacious outdoor patios

ON U.S. 1 AT INTERSECTION N. J. 18 (Opposite Howard Johnson's)

Tel. (201) 828-2400 Licensed by State of New Jersey **NEW BRUNSWICK, N. J.**



CHELATION — (GR-CHELE: CLAW OR TO HOLD.)

The FIRST Hematinic to Contain BOTH CHELATED IRON and CHELATED MINERALS Assuring a Truly Flavorful, Better Tolerated Iron Therapy.

ADVANTAGES —

Chelated Iron PLUS 4 Chelated Minerals • High Therapeutic Effectiveness • Less Irritation — even on empty stomach • No Tooth Stain • Less Toxic • B-Vitamins for Added Hemopoietic Activity • Pleasant Flavor • Economical

KELATRATE

LIQUID HEMATINIC

CHELATED IRON-MINERALS and VITAMINS

FORMULA —

Each 5 cc. (one teaspoonful) contains:

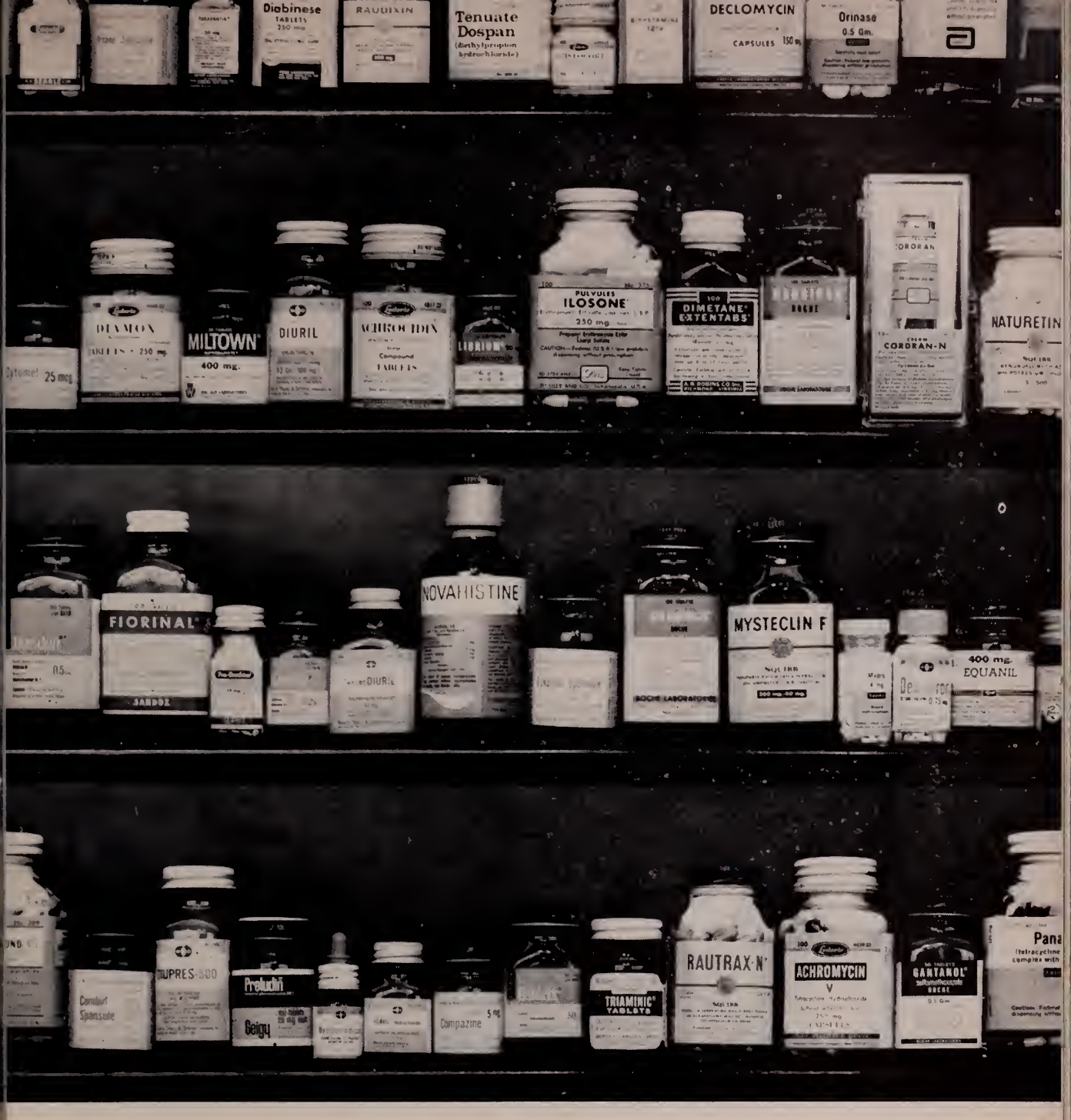
Iron (as Ferrous Betaine Citrate)	30 mg.
Cobalt (as Cobaltous Betaine Citrate)	0.1 mg.
Manganese (as Manganese Betaine Citrate)	1.0 mg.
Zinc (as Zinc Betaine Citrate)	1.25 mg.
Magnesium (as Magnesium Betaine Citrate)	6.0 mg.
Vitamin B-1	1.5 mg.
Vitamin B-2	1.2 mg.
Vitamin B-12	6.0 mcg.
Niacinamide	10 mg.
Panthenol	10 mg.

In an exceptionally pleasant tasting base.

Comprehensive literature and samples on request.

S. J. TUTAG & CO.
DETROIT 34, MICHIGAN

TUTAG



we couldn't begin to get them all into the picture...

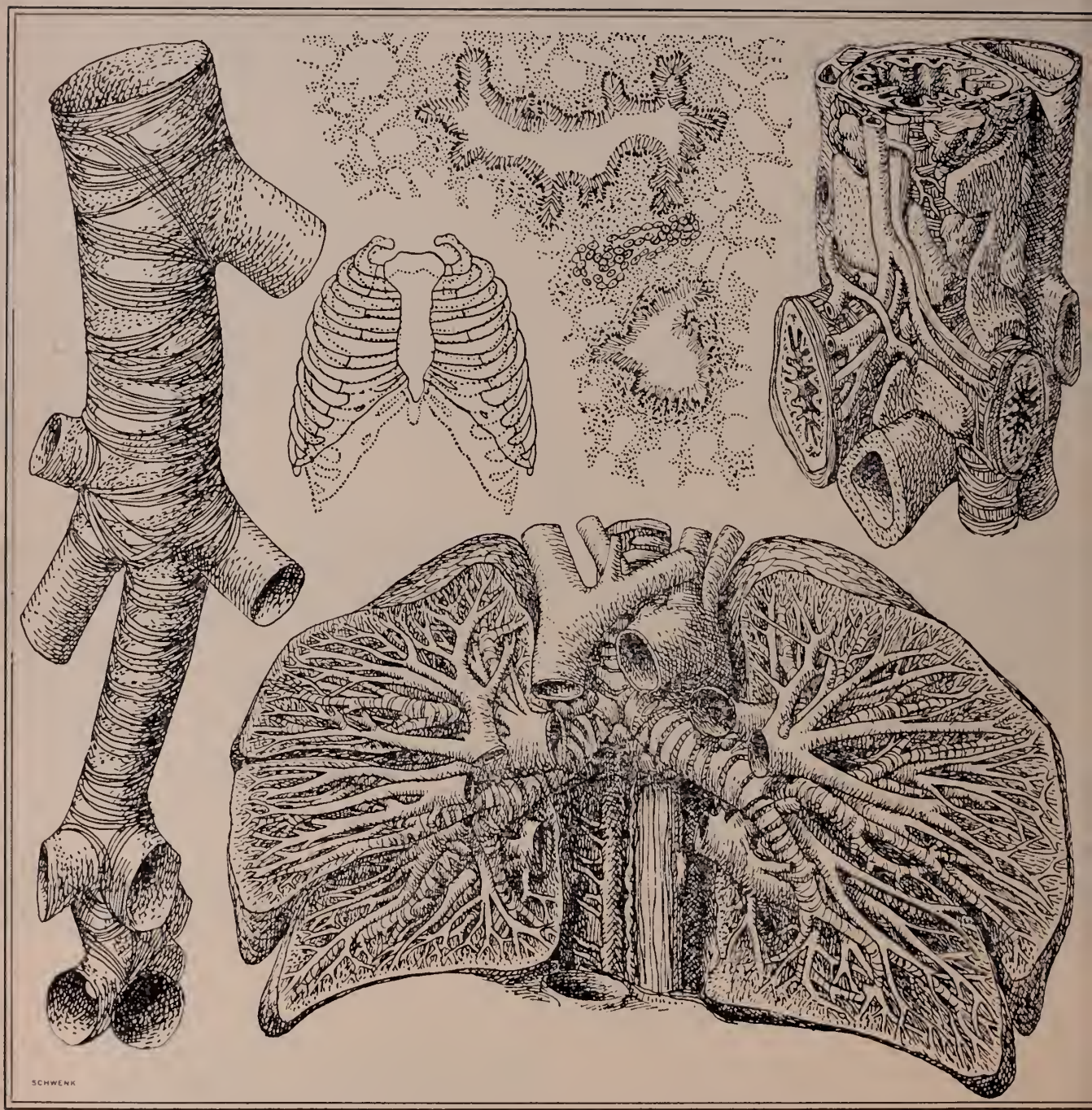
Much has been said and more has been written about the quality of, and the motives behind, independent drug research in this country. So we decided to take a look at what we, as an industry, have done in terms of medical progress over the years.

We made a list of the most frequently prescribed drugs of 1962. We gathered them together to take the picture you see on this page. Then we eliminated all products introduced more than 10 years ago. *But then, for the camera to make the labels legible, it became necessary to eliminate several more.*

Just 10 years ago none of these drugs were available for your prescription. How much would it affect your practice if none were available today?

This message is brought to you on behalf of the producers of prescription products.

PHARMACEUTICAL MANUFACTURERS ASSOC. • 1411 K STREET, N.W. • WASHINGTON, D.C.



SCHWENK

Air Rights

With ARISTOCORT Triamcinolone, many sthmatic patients obtain early gratifying elief of wheezing, dyspnea and spasmodic oughing. And maintenance dosage in many ases can be surprisingly low—*often as little s a single 2 mg. tablet per day.* Yet it proides this symptomatic control—which may nable many patients to continue their cusomary livelihoods or regular household ctivities—with only minimal interference vith other metabolic functions. In this respect, ARISTOCORT Triamcinolone is distinuished compared with other corticosteroids, ld and new. Typical steroid problems of odium retention and edema, euphoria, or oracious appetite and excessive weight gain arely occur.

ARISTOCORT Triamcinolone is indicated vhen anti-inflammatory, anti-allergic action f glucocorticoids is desired. SIDE EFFECTS of glucocorticoids generally: Cushingoid effects, hirsutism, leucopenia, purpura, vertigo, fatigue, increased hyperglycemia, osteoporosis, gastrointestinal hemorrhage, cataracts, growth suppression in children and increased intracranial pressure. Other glucocorticoid effects thought more likely to occur with triamcinolone: reversible weakness of muscles and flushing of face.

PRECAUTIONS: ARISTOCORT Triamcinolone should be used with extreme caution in viral infection, particularly herpes simplex and chicken pox, in tubercular or fungal infection, in active peptic ulcer, acute glomerular nephritis or myasthenia gravis.

FORMULA—Tablets (scored) containing 1 mg., 2 mg. or 4 mg. of triamcinolone. Syrup —2 mg. of triamcinolone diacetate per 5 cc. (5 mg. of triamcinolone diacetate is equivalent to 4 mg. of triamcinolone).

Aristocort®
Triamcinolone

Maximum steroid benefits with minimum steroid penalty

Lederle LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York
162-R3 (DC31-S)

Flavoring Improves Palatability of Acidophilus Milk

In the treatment of acne vulgaris and such gastro-intestinal disorders as simple chronic constipation and simple diarrhea, patient resistance to ingestion of Acidophilus may be controlled if flavor is improved by stirring 1 to 2 teaspoons of Jell-O powder into each glass of Acidophilus Milk before serving. Most popular flavors are raspberry, cherry, orange-pineapple, blackberry, and strawberry. For patients on low-calorie diets, substitute D-Zerta for Jell-O. Add a few drops of Sweeta or Sweet-10 to the flavored Acidophilus for a sweeter drink.

WALKER-GORDON ACIDOPHILUS

2% butterfat, made from Walker-Gordon Certified Milk cultured with 300-500 million acidophilus bacilli per ml. Available through leading milk dealers.

WALKER-GORDON CERTIFIED MILK FARM, Plainsboro, N. J.

SWinburne 9-1234 (N. Y. WAlker 5-7300; Phila. PEnnypacker 5-3465)

RADON • RADIUM

SEEDS • IMPLANTERS • CERVICAL APPLICATORS

THE RADIUM EMANATION CORPORATION

GRAYBAR BUILDING • NEW YORK 17, N. Y.

Wire or Phone MUrray Hill 3-8636 Collect

GREENLEAF FUNERAL HOME

108 West Palisade Avenue

ENGLEWOOD, N. J.

LO 8-0416 Est. 1893

FAIR OAKS HOSPITAL

SUMMIT, NEW JERSEY

CRestview 7-0143

OSCAR ROZETT, M.D.
Medical Director

MOLLIE KENNEDY, R.N.
Director, Nursing Service

EDWARD R. DUTY, M.D.
Clinical Director

N. M. JANI, M.D.
S. D. ESTRADA, M.D.
Associate Psychiatrists

THOMAS P. PROUT, JR.,
Administrator

AN 85 BED INTENSIVE TREATMENT PSYCHIATRIC UNIT

Certified by
The Joint Commission on Accreditation of Hospitals
The Central Inspection Board, American Psychiatric Assn.







"Prescribe With Confidence"

K A T E S B R O S.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

MILLER Barefoot Freedom®

SOLD ON Rx ONLY

CORRECTIVE FOOTWEAR FOR MEN - WOMEN - CHILDREN

OUTFLAIR SHOES FOR CLUB FEET

69 WESTWOOD AVENUE
WESTWOOD, N. J.

350 MAIN STREET
HACKENSACK, N. J.

Dennis Brown Splints — In all sizes — Carried in stock

CUSTOM SHOE SHOP ON PREMISES

The Morristown Rehabilitation Center

66 MORRIS STREET MORRISTOWN, NEW JERSEY

JEFFERSON 9-3000



NATHAN KAPLAN, M.D., Physiatrist

MARY E. JOHNSON, Chief Therapist

ANN G. McMANUS, R.N.
Director of Nursing Service

AUDREY E. TAHLMORE
Administrator

A 38-bed rehabilitation unit specializing in orthopedic and neurological disabilities. Speech therapy, Occupational therapy and psychological evaluation available.

- - - - - -

AMERICAN HOSPITAL ASSOCIATION ACCREDITATION
MEMBER NEW JERSEY LICENSED NURSING HOME ASSOCIATION

MERCK, SHARP & DOHME POSTGRADUATE PROGRAM

The Merck, Sharp & Dohme postgraduate program has been established to facilitate postgraduate medical education. The program supplies funds to medical societies, hospitals, medical schools, educators, and physicians for projects that are designed to help the practicing physician keep abreast of the rapid changes and advances in medicine. The selection of subjects and speakers remains with the applicant. For specific details, please write to the Director of Professional Relations, Merck, Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pennsylvania.

CHANGE OF ADDRESS

In the event of a change of address or failure to receive THE JOURNAL regularly, fill out this coupon and mail at once to

THE MEDICAL SOCIETY OF NEW JERSEY, P.O. Box 904, Trenton, N. J. 08605

Change my address on mailing list

From .....

To .....

Date ..... Signed ..... M.D.

PROFESSIONAL LIABILITY INSURANCE PROGRAM

officially endorsed by

THE MEDICAL SOCIETY OF NEW JERSEY

PROTECTION for Professional Acts and Professional Premises Liability for members of The Medical Society of New Jersey by the First American Liability Insurance Company.

LOSS CONTROL. Your County Medical Review and Advisory Committee will evaluate malpractice cases and recommend the action which would be most favorable for the Medical Profession, the Defendant Doctor, the Patient and the Public. This program permits understanding of the complex problems involved in such cases and calls for close cooperation between the Medical Profession and Insurance Company.

MEDICO-LEGAL FORMS are furnished to each insured doctor to help in reducing claims or dissatisfied patients. Failure to use forms does not affect the doctor's insurance coverage or his eligibility for insurance.

INSURANCE COUNSELING. Insurance counseling and advice, available at all times, without cost, to help you with your Professional Liability insurance problems.

CANCELLATION. No policy will be cancelled or non-renewed without prior consultation between your Society and the Company and this is a matter of complete cooperation for the best interests of all concerned.

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY

Policies Guaranteed Non-assessable

Professional Liability Department

123 CLEVELAND STREET — ORANGE, NEW JERSEY

Joseph A. Britton, Manager — ORange 3-2575

Home Office: Wakefield, Mass.

PARKWAY NURSING HOME



1201 PARKWAY AVE.
Trenton, N. J.
Tel. 882-6900

No Steps!
Ranch Type
New audio-visual
call system
from every patient
to Nurses.

One of New Jersey's newest, most modern and completely equipped Nursing and Convalescent Homes, catering to the Convalescent, Aged, and Chronically Ill. Private and Semi-private rooms.

- Referring physician has full medical privileges
- Complete 24-hour general nursing care
- Physical rehabilitation department
- Beauty parlor. Air-conditioned dining room, lounge, and lobby. Spacious patios.
- Ultra modern interiors with artistic color scheme
- Stainless steel kitchen tiled to ceiling
- Special diets. Planned social and recreational activities
- Residential section

REASONABLE RATES — YOUR INSPECTION INVITED

PARKWAY NURSING HOME

Registration Approved by American Hospital Association
Member: Licensed Nursing Homes Assn. of N. J.
Approved to Accept Blue Cross Patients
Member: American Nursing Home Association
NEW JERSEY STATE LICENSED

ANNUAL CLINICAL CONFERENCE

Chicago Medical Society

MARCH 2, 3, 4 and 5, 1964

PALMER HOUSE, CHICAGO

LECTURES
TEACHING DEMONSTRATIONS
MEDICAL COLOR TELECASTS
FILM LECTURES
INSTRUCTIONAL COURSES

The CHICAGO MEDICAL SOCIETY ANNUAL CLINICAL CONFERENCE should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.

LONG TERM AUTO LEASING

. . . A SERVICE ESPECIALLY PLANNED FOR DOCTORS!

M.D. PLATES FREE, TOO!

AAL LONG TERM SINGLE CAR AND FLEET RENTALS

Call ORange 6-7137 or

MAIL COUPON TODAY

Lease a brand new Cadillac or other fine car from American and you'll never **buy** again. Save money, time and trouble. One modest monthly payment takes care of everything . . . insurance, maintenance, repairs, depreciation . . . and the payments are 100% tax deductible! Borrow a car—free of charge—in case of accident or breakdown.

INCLUDES

- Registration and plates
- Full maintenance
- Insurance

Liability $250/$500,000
Property damage $20,000
Deductible collision,
fire and theft

AMERICAN AUTO LEASING COMPANY
120 Halsted St., East Orange, N. J.
Please send me the AAL Long Term Leasing Plan.

Wide Selection of '63 Models

Special requirements _____

_____

Name _____

Address _____

City _____ State _____

ALL YOU BUY IS GAS AND OIL

ASK FOR BROCHURE

AAL

AMERICAN AUTO LEASING COMPANY

120 Halsted Street, East Orange, New Jersey • ORange 6-7137

Office Suites Available - New Medical Building
Kinnelon, New Jersey

Area in need of general practitioner, surgeon, obstetrician, pediatrician, dentist.

HENRY D. RICKER, Broker **BUTLER, NEW JERSEY — TE 8-0400**

Raymond A. Lanterman & Son

Exclusive Funeral Service

126 SOUTH STREET MORRISTOWN, N. J.

PHONE JE 9-2880

R. A. Lanterman Wm. V. D. Lanterman

ORANGE PUBLISHING CO.

PRINTERS

116 LINCOLN AVENUE ORANGE, NEW JERSEY

CLASSIFIED ADVERTISEMENTS

Send replies to box number, c/o THE JOURNAL
P. O. Box 904, Trenton, New Jersey 08605

$5 for 25 words or less; additional words 10c each
Payable in advance of publication

Forms close 15th of the preceding month.

HOUSE PHYSICIAN — ECFMG or state licensure, 155-bed accredited, general hospital; 32 miles Philadelphia $8,400 plus benefits. Apply Administrator, Salem County Memorial Hospital, Salem, New Jersey.

POSITION OPEN—Director of Pathology, 400-bed, JCAH accredited, community, voluntary general hospital. Modern well-staffed laboratory, fully accredited blood bank, and approved four-year residency program. Must be certified both boards. Write: Sr. Dorothy Reece, Administrator, St. Peter's General Hospital, Easton Avenue, New Brunswick, New Jersey.

ANESTHESIOLOGIST—To associate group partnership practice in new, 100-bed, general hospital, Hollywood, California. Write Box No. 84, c/o THE JOURNAL.

GENERAL PRACTITIONER—Small group. Northern New Jersey metropolitan area. Experienced. Salary with eventual partnership. Internist would also be considered. Write Box No. 78, c/o THE JOURNAL.

OPHTHALMOLOGIST—Wanted to occupy office in new medical building in desirable New Jersey suburban community adjacent Philadelphia. Hospitals nearby. Building currently houses offices for seven other medical specialists. Write Box No. 87, c/o THE JOURNAL.

PHYSICIAN—Share new building with dentist. A medical doctor is in demand in boom area near Toms River, New Jersey, Fischer Boulevard and Bay Avenue. Phone 531-1050.

WANTED—Well-trained general practitioner or internist to join long-established general practitioner with large practice. New, fully equipped building. Fine hospital. One year salary, then partnership. Leo Lewin, M.D., Mount Arlington, New Jersey. Phone: 398-0870.

PHYSICIANS WANTED—The out-patient department of large, voluntary Manhattan hospital has vacancies on its Rheumatology and Arthritis staff, afternoon sessions. Opportunities for ward service available and for training in rheumatic disorders and the use of current proccdures. Physicians interested write Box No. 88, c/o THE JOURNAL.

CERTIFIED NEUROLOGIST—Eligible in psychiatry, desires association with a group or individual. Experienced in EEG, EMG, angiography, myelography, etc. New Jersey license. Write Box No. 79, c/o THE JOURNAL.

ASSOCIATE WANTED—Young internist (cardiologist) desires associate, preferably gastroenterologist, for the practice of internal medicine, primarily in hospital setting. Thirty minutes from Philadelphia. Opportunity for academic affiliation. Write Box No. 82, c/o THE JOURNAL.

PRACTICE FOR SALE—25-year-old practice for internist or general practitioner in Monmouth County, New Jersey. Beautiful 5-year-old brick home and large 5½-room office; including 100 Ma. x-ray, all new equipment, air-conditioned. Sudden death of physician. Gross well over $50,000. Financing arranged or salary basis. H. M. Swartz, M.D., 138 Cherry Tree Farm Road, Middletown, New Jersey. OS 1-3313.

GENERAL PRACTICE FOR SALE—Well-established active general practice with large growth potential by comparatively young doctor. Ideal highest income area Bergen County, New Jersey. Convenient to NYC. Suitable for internist or group. Open staff hospital nearby. Attractive modern air-conditioned, centrally located building designed for professional use. Full introductions. Attractive price. Rental includes full use of furnishings and equipment at no additional cost. Terms can be arranged. Family estate plans demand full time of seller. Complete details available. Professional Business Consultants, 6 Passaic St., Hackensack, N. J. 343-9414.

FOR SALE—X-ray equipment. Picker-Waite for GI and related x-ray and fluoroscopic work. Bought new in 1946; fluoroscope tube new in 1950. Excellent working condition. Generator, monitor, stabilizer, timer, Bucky, spot film device, serialographic tunnel, motor-powered tilting radiographic table—all in tip-top shape ready for use. Write Box No. 83, c/o THE JOURNAL.

FOR SALE—Home-office combination. Middletown, New Jersey. Excellent central location in fastest growing community of Monmouth County. Three-bedroom split level, separate entrances, parking area. Low cash investment. Write Box No. 85, c/o THE JOURNAL.

IRVINGTON—600-square-foot suite remaining in new professional building, presently occupied by dentist, allergist, optometrist, and speech therapist. 1146 Stuyvesant Avenue. ES 3-1073, MU 6-0787.

FOR RENT—North Bergen. Share active general practitioner's ten-room office. All facilities provided. Large parking area near all transportation. Specialist desired. Write Box No. 73, c/o THE JOURNAL.

CLASSIFIED (Continued)

FOR SALE CALDWELL—Home-office combination. Seven-room office complete with laboratory and central air-conditioning. Convenient to Bloomfield Avenue. Three bedroom home separate from office with two-car garage and play area. Local well-established. Call CA 6-8585.

FOR SALE—Ranch home-office, Orange, New Jersey. Little cash needed. Excellent location. Brochure on request. Bernard M. Degnan, Realtor, 331 Main Street, West Orange. Ask for Bob Scovill at DA 5-1500.

FOR SALE—Office and home, two blocks from Irvington Center. Retiring after 25 years practice. Write Box No. 86, c/o THE JOURNAL.

OFFICE TO SHARE—Upper Montclair. Completely equipped. Air-conditioned. 500 ma. x-ray, EKG, etc. PI 4-3636.

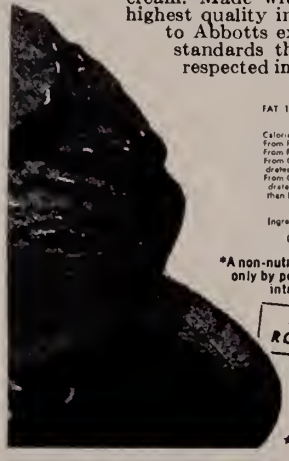
POSITION WANTED—Medical Assistants and Secretaries. Laboratory and X-ray Techs. September and February Graduation. Well trained and highly qualified personnel (male and female) also available at other times. Phone CH 2-2330, Ext. 17, Placement Department; or write Physician Director, Eastern School for Physicians' Aides, Dept. 7, 85 Fifth Avenue, New York 3, New York.

FOR SALE—Lease or locum tenens. Complete eight-room office at Jersey Shore. Phone 793-0263.

NOW! DIABETICS CAN ENJOY
(UNDER MEDICAL ADVICE)

Abbotts
ARTIFICIALLY SWEETENED
ICE CREAM

Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards—standards that are most highly respected in the dairy industry



COMPOSITION
FAT 10.52% PROTEIN 3.71%
CARBOHYDRATES 20.40%

	Cals.	Oz. Avoir.	Oz. Fluid
Calories — Per 100 Gm.			
From Fat	94.68	26.84	16.25
From Protein	14.84	4.21	2.55
From Carbohydrates as Lactose	20.24	5.74	3.47
From Carbohydrates other than Lactose	61.68	17.48	10.58
	191.42	54.27	32.85

Ingredients: Cream, Milk, Sorbitol, Stabilizer and 0.11% Cyclamate Calcium*

*A non-nutritive artificial sweetener for use only by persons who must restrict their intake of ordinary sweets.

IN HANDY ROUND PINTS

At Abbotts and Jane Logan Dealers
Abbotts Dairies



Protects your angina patient better than vasodilators alone

'Miltrate' contains both pentaerythritol tetranitrate, which dilates the patient's coronary arteries, and meprobamate, which relieves his anxiety about his condition. Thus 'Miltrate' protects your angina patient better than vasodilators alone.

Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

Dosage: 1 or 2 tablets *before meals* and at bedtime. Individualization required.
Supplied: Bottles of 50 tablets.

CML-9646

Miltrate®
meprobamate 200 mg.+
pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*



Helps to make the epileptic's life more meaningful

Dilantin® Kapseals®
(Diphenylhydantoin sodium)

PARKE-DAVIS

With modern, intelligent therapy, epilepsy has an excellent prognosis. "Well over 90 per cent of the patients can be adequately controlled so that they can lead a normal life and take a useful and respectable position in society."[1]

Diphenylhydantoin sodium is generally regarded as the standard in anticonvulsant medication because of its effectiveness in controlling grand mal and psychomotor seizures.[2-10] It possesses a wide margin of safety, and the incidence of side effects is minimal.[4] With this agent, oversedation is not a problem.[3] Moreover, its use is often accompanied by improvement in the patient's memory, intellectual performance, and emotional stability.[11]

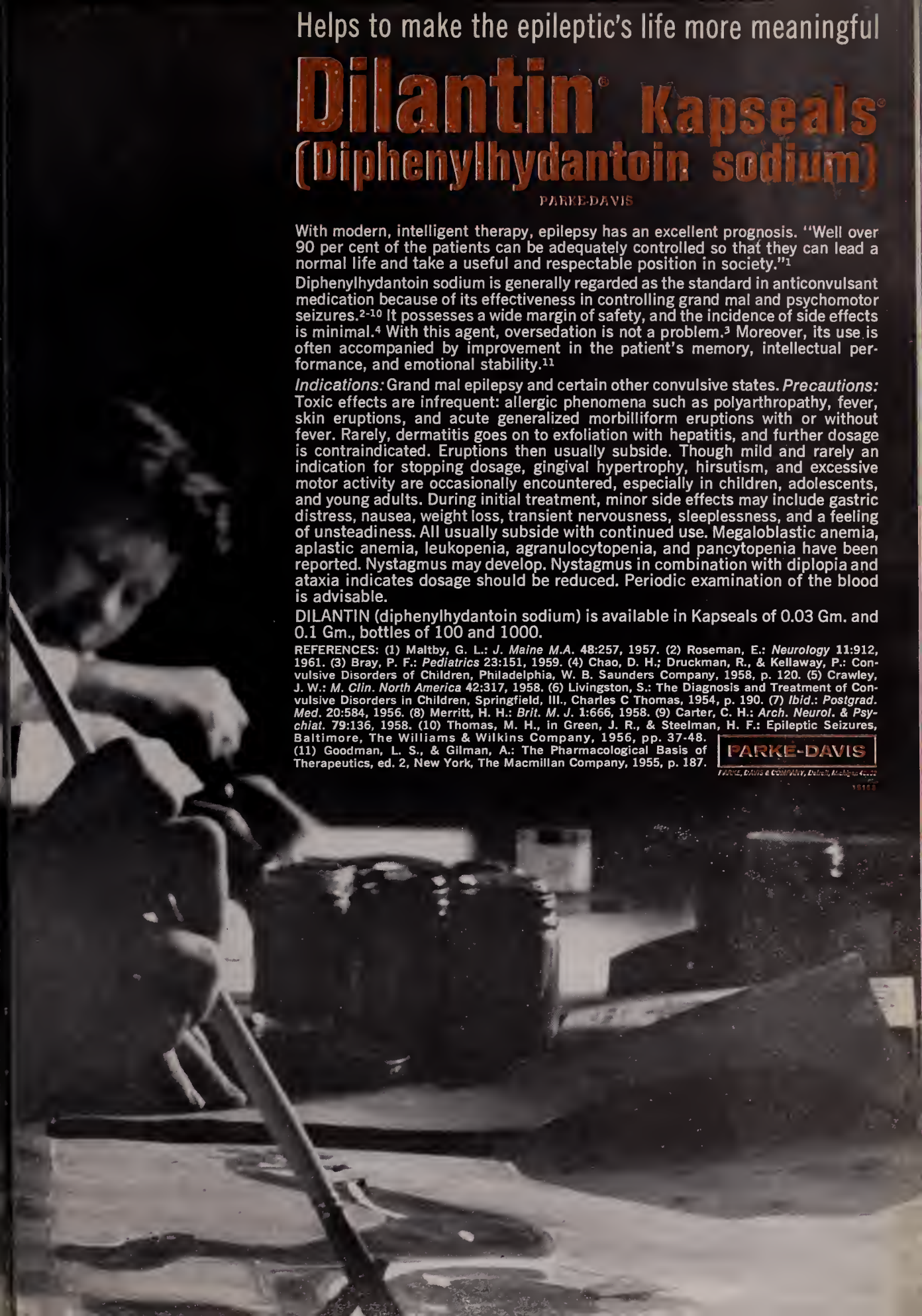
Indications: Grand mal epilepsy and certain other convulsive states. *Precautions:* Toxic effects are infrequent: allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Eruptions then usually subside. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Megaloblastic anemia, aplastic anemia, leukopenia, agranulocytopenia, and pancytopenia have been reported. Nystagmus may develop. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. Periodic examination of the blood is advisable.

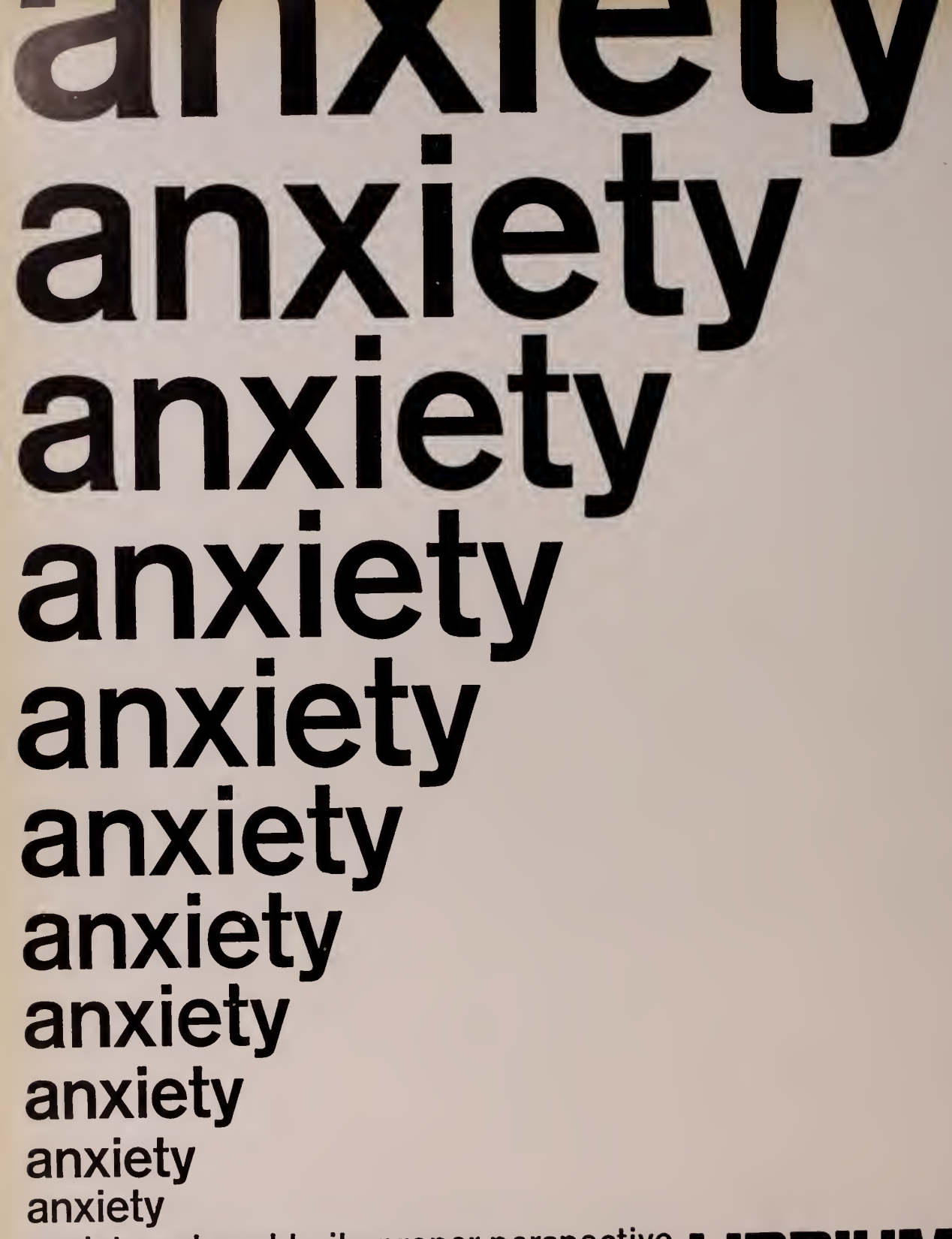
DILANTIN (diphenylhydantoin sodium) is available in Kapseals of 0.03 Gm. and 0.1 Gm., bottles of 100 and 1000.

REFERENCES: (1) Maltby, G. L.: *J. Maine M.A.* 48:257, 1957. (2) Roseman, E.: *Neurology* 11:912, 1961. (3) Bray, P. F.: *Pediatrics* 23:151, 1959. (4) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (5) Crawley, J. W.: *M. Clin. North America* 42:317, 1958. (6) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (7) *Ibid.*: *Postgrad. Med.* 20:584, 1956. (8) Merritt, H. H.: *Brit. M. J.* 1:666, 1958. (9) Carter, C. H.: *Arch. Neurol. & Psychiat.* 79:136, 1958. (10) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (11) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit, Michigan, U.S.A.





LIBRIUM®
(chlordiazepoxide HCl)
the successor
to the tranquilizers

ROCHE

In prescribing: Dosage—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. Cautions—Occasional side effects, often dose-related, are drowsiness, ataxia, minor skin rashes, menstrual irregularities, nausea and constipation. Paradoxical reactions may occasionally occur in psychiatric patients. Individual maintenance dosages should be determined. Advise patients against possibly hazardous procedures until maintenance dosage is established. Though compatible with most drugs, use care in combining with other psychotropics, particularly MAO inhibitors or phenothiazines; warn patients of possible combined effects with alcohol. Observe usual precautions in impaired renal or hepatic function, and in long-term treatment. Caution should be exercised in prescribing any therapeutic agent for [illegible] Supplied: Capsules, 5 mg, 10 mg and 25 mg, bottles of 50 and 500.

INDEX NUMBER

THE Journal OF THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since 1904
Copyright 1963 by The Medical Society of New Jersey

Entered as second-class matter Sept. 5, 1906, at the post office, Orange, N. J., under Act of March 3, 1879
Second-Class Postage Paid at Orange, N. J.

VOL. 60, NO. 12 DECEMBER, 1963 50 Cents - $5.00 PER YEAR

THE NEW YORK ACADEMY OF MEDICINE
DEC 23 1963
LIBRARY

CONTENTS—Pages 537 to 578

EDITORIALS— Page

TB and Health Association 537
Our Half Century With OPC 538

ORIGINAL ARTICLES—

Continuing Education for the Physician— Paul B. Ferrary, M.D., Paterson 539

Lump in the Neck—William J. Follette, M.D., Englewood 542

Institutionalization of Infants — V. Terrell Davis, M.D., Trenton 545

Anti-Depressant Drug Combinations—Theodore R. Robie, M.D., East Orange 547

Stevens-Johnson Disease in Infants—Seymour L. Hanfling, M.D., and William B. Nevius. M.D., East Orange 555

ORIGINAL ARTICLES— Page

Perforated Abdominal Aneurysm Presenting Azotemia — E. N. Mattioli, M.D., and Charles Cunningham, M.D., Vineland 559

Pathology of Trauma in Disability Evaluation—Sidney Keats, M.D., Newark 562

PSYCHOSOMATIC PROFILE 541

STATE ACTIVITIES—

Study of Cooley's Anemia 544
Trustees' Meeting: October 20, 1963 565
Psychosomatics in Reverse 566

ANNOUNCEMENTS 567

BOOK REVIEWS 568

ANNUAL INDEX 1963 570

RESPIRATORY DISEASE ABSTRACTS 577

Roster of Officers, Advertising Page 3A

The Medical Society of New Jersey

Endorsed Insurance Plans

ACCIDENT AND HEALTH INSURANCE

$ 1,200 a month new maximum Basic total disability benefit

ACCIDENT: from 1st day, up to 5 years (Partial Accident Disability, half benefit up to six months)
SICKNESS: from 8th day, up to 2 years

$600 a month new maximum Extended total disability benefit, continuing benefits beyond basic coverage.

ACCIDENT: extended to LIFE
SICKNESS: extended through SEVENTH year

MAJOR MEDICAL EXPENSE INSURANCE

$10,000 maximum for Covered Expenses for each accident or sickness, covering member, spouse, and eligible children. Plan pays 80% Covered Expenses after $500 deductible.

LIFE INSURANCE

$10,000 to **$50,000** of Convertible Term Life Insurance.

(Guaranteed exchangeable at any time into Permanent Cash Value life insurance without medical examination)

Applications for initial $10,000 policy and additional $10,000 policies up to $50,000 total under this plan considered during the month of November each year.

SIX POINT, HIGH LIMIT ACCIDENT INSURANCE

Up to $200,000 for member, covering accidental death, dismemberment, loss of sight, total and permanent disability, exposure and disappearance.

Up to $100,000 for spouse (without disability benefit).

Applications are subject to age limits and other company rules and regulations for acceptance of risk. New members have special privileges during the first few months of membership; ask for specific details if you were recently elected and have not received notification from us.

Information and claim service are as close as your telephone.

E. & W. BLANKSTEEN

E. & W. Blanksteen Agency, Inc.

75 MONTGOMERY STREET JERSEY CITY, NEW JERSEY 07302

DElaware 3-4340 (Area Code 201)

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATON, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.
EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154
(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

OFFICERS

President, Jerome G. Kaufman, M.D. ..... Maplewood
President-Elect, Charles H. Calvin, M.D. ..... Perth Amboy
First Vice-President, John J. Bedrick, M.D. .....Bayonne
Second Vice-President, Joseph R. Jehl, M.D. ..... Clifton
Secretary, Marcus H. Greifinger, M.D. .....Newark
Treasurer, Daniel F. Featherston, M.D. ..... Asbury Park

Richard I. Nevin, *Executive Director* ..... Trenton
Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton

TRUSTEES

Samuel J. Lloyd, M.D., *Chairman* (1966) ..... Trenton
Nicholas A. Bertha, M.D., *Secretary* (1965) ..... Wharton
Jerome G. Kaufman, M.D. ..... Maplewood
Charles H. Calvin, M.D. ..... Perth Amboy
John J. Bedrick, M.D. ..... Bayonne
Joseph R. Jehl, M.D. ..... Clifton
Marcus H. Greifinger, M.D. ..... Newark
Daniel F. Featherston, M.D. ..... Asbury Park
Louis S. Wegryn, M.D. ..... Elizabeth
Louis F. Albright, M.D. (1964) ..... Spring Lake
Louis K. Collins, M.D. (1964) ..... Glassboro
Thomas C. DeCecio, M.D. (1965) ..... Cliffside Park
Joseph P. Donnelly, M.D. (1966) ..... Jersey City
Lloyd A. Hamilton, M.D. (1965) ..... Lambertville
Frank J. Hughes, M.D. (1966) ..... Gloucester
John F. Kustrup, M.D. (1966) ..... Trenton
Emanuel M. Satulsky, M.D. (1964) ..... Elizabeth
Carl N. Ware, M.D. (1965) ..... Ocean City

COUNCILORS

First District (Essex, Morris, Union, and Warren Counties) ..... Thomas S. P. Fitch, M.D., Plainfield (1966)
Second District (Bergen, Hudson, Passaic, and Sussex Counties) ..... John L. Olpp, M.D., Englewood (1965)
Third District (Hunterdon, Mercer, Middlesex, and Somerset Counties) ..... Albert F. Moriconi, M.D., Trenton (1964)
Fourth District (Burlington, Camden, Monmouth, and Ocean Counties) ..... E. Vernon Davis, M.D., Moorestown (1966)
Fifth District (Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties) .... Isaac N. Patterson, M.D., Westville (1965)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell, M.D. (1964) ..... Asbury Park
William F. Costello, M.D. (1963) ..... Dover
Joseph P. Donnelly, M.D. (1965) ..... Jersey City
Marcus H. Greifinger, M.D. (1964) ..... Newark
Luke A. Mulligan, M.D. (1964) ..... Leonia
Isaac N. Patterson, M.D. (1965) ..... Westville

Alternates

F. Clyde Bowers, M.D. (1964) ..... Mendham
Frank J. Hughes, M.D. (1964) ..... Gloucester
Joseph R. Jehl, M.D. (1965) ..... Clifton
John F. Kustrup, M.D. (1964) ..... Trenton
Elton W. Lance, M.D. (1965) ..... Rahway
John L. Olpp, M.D. (1963) ..... Englewood

DELEGATES TO OTHER STATES

New York—William F. Costello, M.D. (1963) ..... Dover
Connecticut—Lloyd A. Hamilton, M.D. (1963) .. Lambertville
New York—G. Ruffin Stamps, M.D. (1963) .... Atlantic City
Connecticut—S. Eugene Dalton, M.D. (1963) ..... Ventnor

Scientific Sessions — 1964 Annual Meeting

Your Program Committee and Section Officers have arranged a broad scientific program for next May. Plan to attend the annual meeting and hear one or more of the following:

Symposiums: Early Diagnosis of Lesions of the Breast and Lesions of the Vulva; Fractures and Dislocations; Vascular Problems of the Extremities; Emergency Preparedness and the Physician; Advances in Diagnosis of Carcinoma of the Stomach; Diabetes Mellitus; Diagnostic Aids in Rheumatic Diseases; The Esophagus; Prelude to Cardiac Surgery.

Panel Discussions: Lower Urinary Tract Problems in Children; Pediatric Allergy; Repository Treatment of Allergic Disease; Identification and Treatment of the Alcoholic; Treatment of Strabismus and Amblyopia.

Individual Papers: Endocrine Control of Renal Function; Diseases of the Thyroid Gland; B-Complex Vitamin Deficiency; Syphilis; Hirsutism and Electrolysis; Nummular Eczema and Athlete's Foot; Dermatology; Visiting Homemaker; Sexual Murderer; Institutionalized Patient.

The advance program will be mailed to all members early in the new year.



it's a long walk from gate 6...

It's a long walk from almost *anywhere* for anyone suffering the excruciating, itching discomfort of *pruritus vulvae.* ARISTOCORT Triamcinolone Acetonide Cream is highly active against the embarrassing and intolerable irritation of pruritus ani and vulvae. Sparing application to the affected area—3 to 4 times daily—usually provides rapid relief. And when excoriation of the area has led to infection, the choice of NEO-ARISTOCORT Neomycin Sulfate-Triamcinolone Acetonide will assure activity against a wide range of skin pathogens. A possible side effect may be local skin sensitization due to neomycin. Contraindications (both forms): tuberculosis of the skin, herpes simplex, and chicken pox. Prescribe tubes of 5 or 15 Gm. Also available in ½ lb. jars.

Aristocort® TOPICAL CREAM 0.1% AND OINTMENT 0.1%
Triamcinolone Acetonide

Neo-Aristocort® CREAM 0.1% AND OINTMENT 0.1%
Neomycin Sulfate (0.5%)—Triamcinolone Acetonide (0.1%)

Colds haven't changed— but relief has with NTz® NASAL SPRAY

NTz Nasal Spray gives on-the-spot relief for stopped-up noses instantly. Recommended by doctors for 10 years, it provides not one, but three powerful ways to fast relief.

In a carefully balanced formula, NTz contains:

Neo-Synephrine® HCl to shrink swollen nasal tissues and provide enough space for breathing

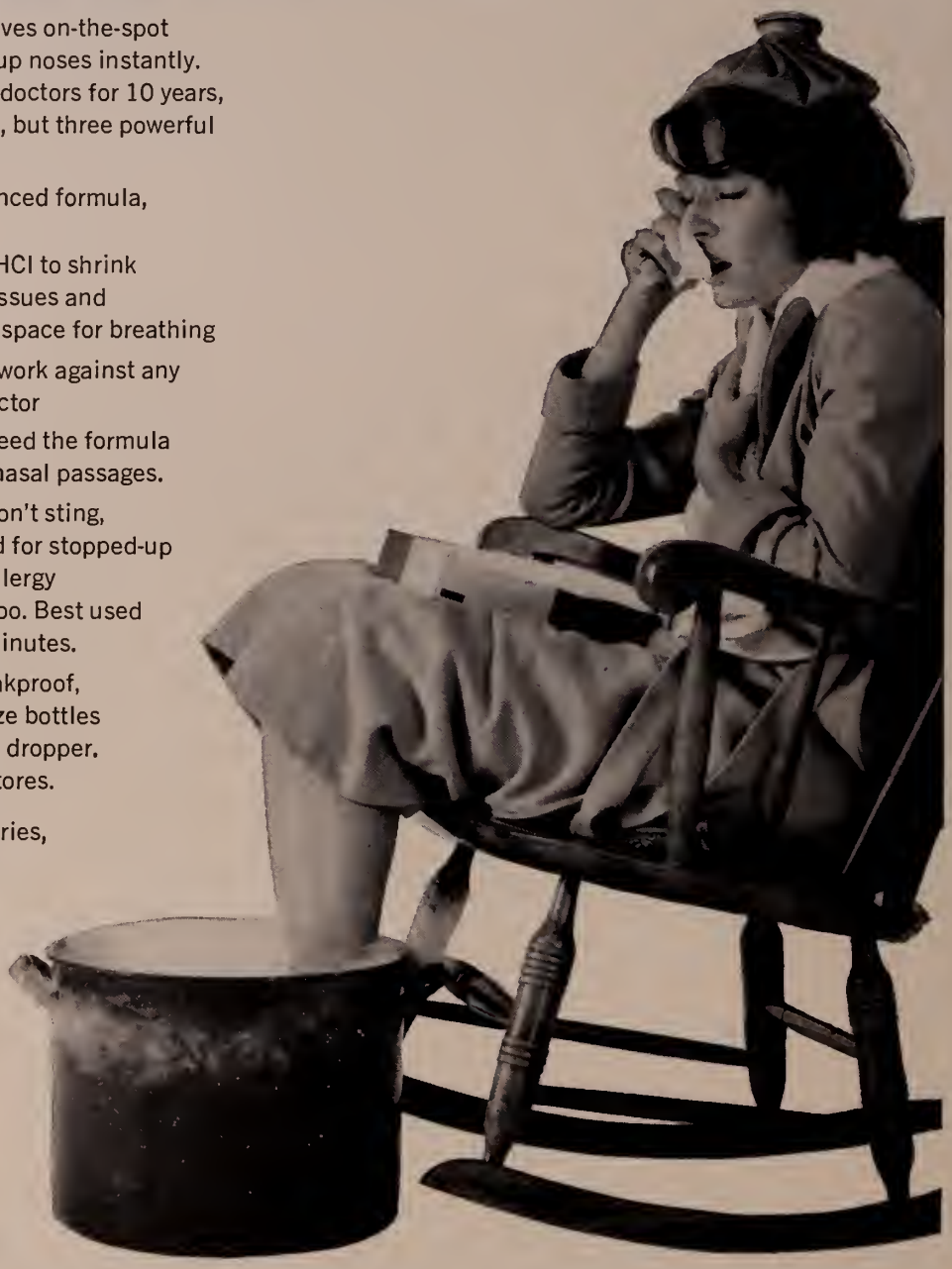
Thenfadil® HCl to work against any local allergic factor

Zephiran® Cl to speed the formula through **all** the nasal passages.

NTz Nasal Spray won't sting, won't irritate. Good for stopped-up noses caused by allergy and for sinusitis, too. Best used **twice** within five minutes.

NTz supplied in leakproof, pocket-size squeeze bottles and in bottles with dropper. Sold only in drugstores.

Winthrop Laboratories, New York 18, N. Y.



Winthrop

NTz, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U. S. Pat. Off.

Important news in cardiac therapy

Two new clinical reports document successful long-term treatment of ischemic heart disease with

Persantin®, brand of dipyridamole

See next 3 pages

Study 1.
Griep,A.H.: Long-term Therapy of Ischemic Heart Disease With Oral Dipyridamole:
A Report of Fifty Cases. Angiology 14:484, 1963.

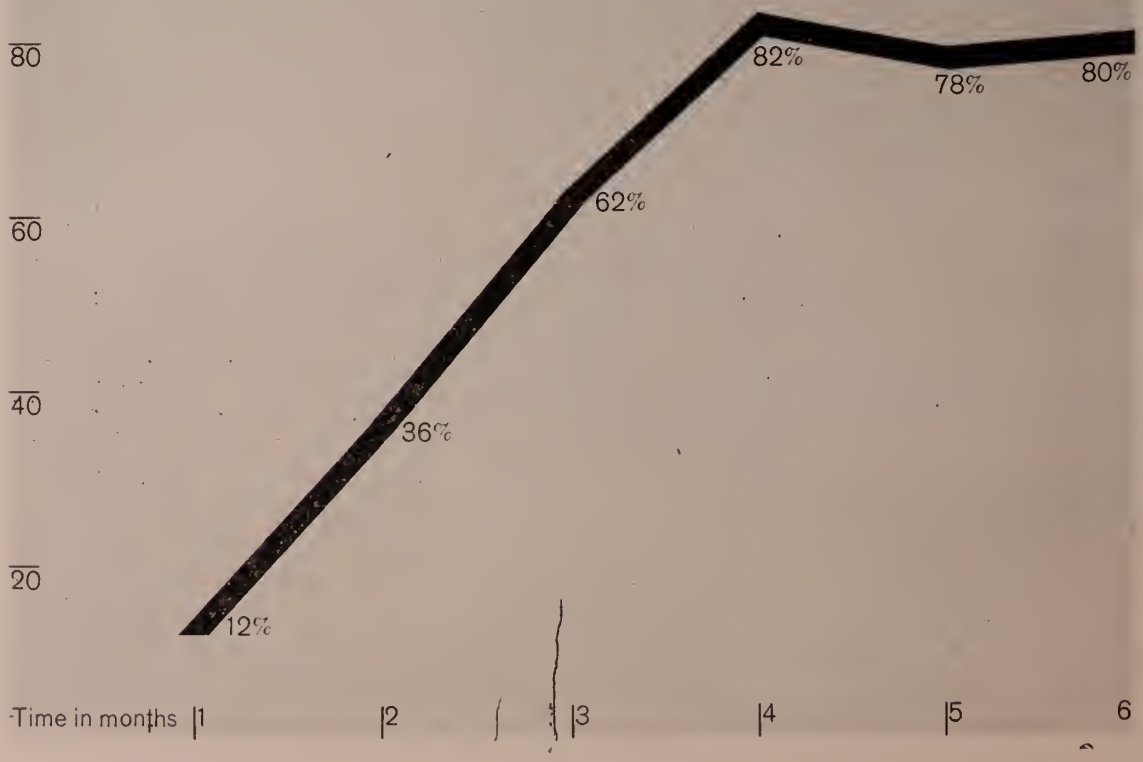
Persantin,® brand of dipyridamole, 25 mg. t.i.d. or q.i.d.,was administered continuously for 6 months to 50 patients with well authenticated ischemic heart disease with angina pectoris and ECG abnormalities. Results were evaluated on a monthly basis.

Persantin® brand of dipyridamole

"...long-term oral therapy with dipyridamole was of benefit in 80 per cent of the patients...

"relief [of angina] came slowly and was usually maximal after three to six months of continuous treatment"

Steady, month-by-month improvement with Persantin,® brand of dipyridamole, refutes possibility of "placebo response", reflects gradual improvement in underlying pathology.



Study 2.
Wirecki,M.: Dipyridamole (Persantin®): Evaluation of Long-Term Therapy in Angina Pectoris. Current Therapeutic Research 5:472, 1963.

In 40 ambulatory patients with myocardial ischemia, angina pectoris, and abnormal ECG findings, Persantin,® brand of dipyridamole, 25 mg. t.i.d., was administered continuously for 3 months.

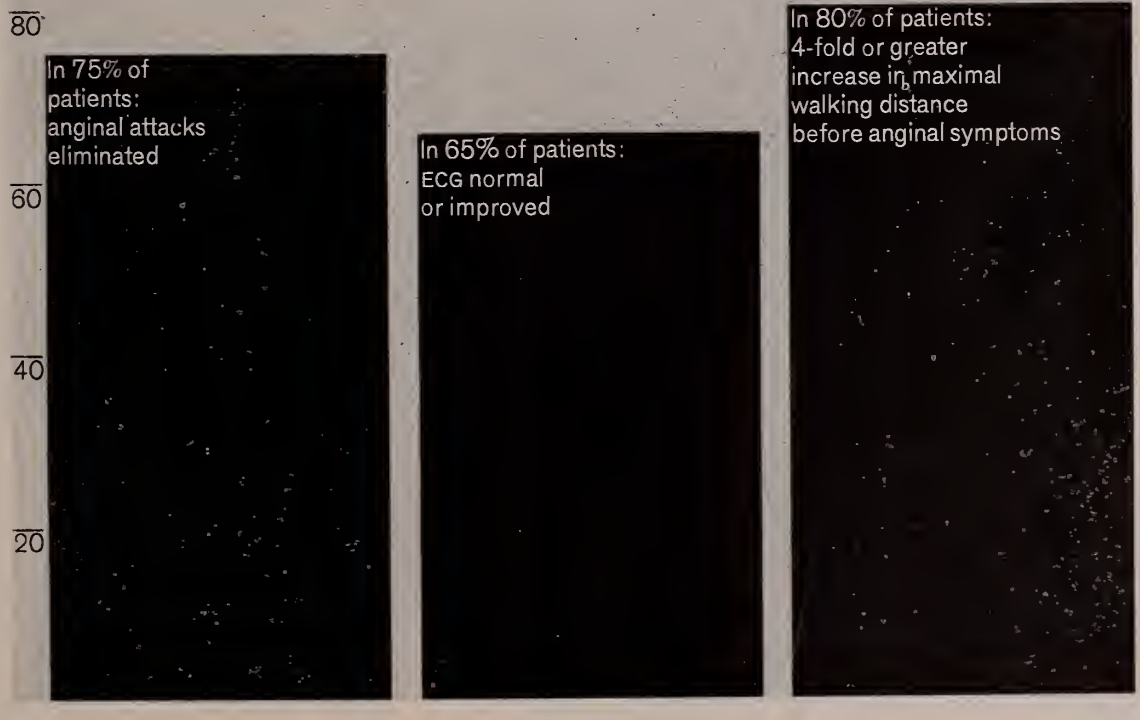
Geigy

After 3 months, 32 of 40 patients showed:

"...reduction or abolition of acute anginal attacks...

"complete or almost complete disappearance of ECG abnormalities...

"marked increase" in walking distance without anginal symptoms



Persantin® brand of dipyridamole

How long-term therapy provides clinical benefits reported on previous pages

1. By increasing energy yield
of the hypoxic myocardial cell, by direct action upon the sarcosomes (heart mitochondria).[1-5]

2. By improving collateral coronary circulation.
Prolonged oral administration of dipyridamole to animals with experimentally induced stenosis of a major coronary artery resulted in superior development of collateral coronary anastomoses and longer survival compared with controls.[6-9]

When given for prolonged periods and in adequate dosage, dipyridamole improves the coronary flow deficit of the ischemic myocardium while supporting cardiac metabolism during the period of repair. Clinically, this is manifested as steady improvement – anginal attacks diminish in frequency and intensity, as do other manifestations of insufficiency (dyspnea, fatigue, and, in many instances, abnormal electrocardiographic findings).

Availability:
Tablets of 25 mg., bottles of 100 and 1000.
Under license from Boehringer Ingelheim G.m.b.H.

Prescribing summary: Persantin,® brand of dipyridamole, is indicated in coronary and myocardial insufficiency, in a dosage of 2 to 6 tablets daily in divided doses before meals for several weeks. Side effects (headache, dizziness, nausea, flushing, weakness, syncope, mild gastrointestinal distress) are minimal and transient. The drug is not recommended in the acute phase of myocardial infarction, and should be used cautiously in hypotension.

References: 1.Kunz,W.;Schmid,W.,and Siess,M.: Arzneimittel-Forsch.12:1098,1962. 2.Siess,M.: Arzneimittel-Forsch.12:683,1962. 3.Laudahn,G.: Experientia 17:415,1961. 4.Lamprecht,W.: 27th Congress of the German Society for Circulation Research,Bad Nauheim,1961. 5.Hockerts,T.,and Bögelmann,G.: Arzneimittel-Forsch.9:47,1959. 6.Vineberg,A.M.,et al.: Canad.M.A.J.87:336,1962. 7.Chari,S.R.,et al.: Presented at the International Congress of Chest Physicians,New Delhi,1963. 8.Neuhaus,G.,et al.: Presented at the Fourth World Congress of Cardiology,Mexico City,1962. 9.Asada, S.,et al.: Japanese Circ.J.26:849,1962.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York, Distributors

PE-2290

cut Rx writing by 2/3 in colds, flu or grippe

NAME _____

ADDRESS _____

℞

No need to write three separate prescriptions for antitussive, decongestant and analgesic relief of common cold, flu or grippe symptoms when it is therapeutically correct... economically sound... to specify

ANTITUSSIVE/DECONGESTANT/ANALGESIC 'EMPRAZIL-C'® TABLETS

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Phenacetin	150 mg.
Aspirin	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming

'Emprazil-C' Tablets are available on prescription only.

Dosage: Adults and children over 12 years—1 or 2 tablets—3 times daily as required. Children 6 to 12 years—1 tablet—3 times daily as required. **Caution:** While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed. **Supplied:** Bottles of 100 tablets.

Also available without codeine as 'EMPRAZIL'® TABLETS

Complete literature available on request from Professional Services Dept. PML.



BURROUGHS WELLCOME & CO (U.S.A.) INC.

Tuckahoe, N. Y.

there is nothing "new" about Thorazine®



brand of

chlorpromazine

In the nine years since it became available to American physicians, Thorazine (chlorpromazine, SK&F) has been more widely used, more thoroughly investigated and more extensively documented than any other agent of its type.

Its actions, effects—and side effects—are well known throughout the medical profession. Its efficacy has been clearly demonstrated. And when properly used, its advantages far outweigh any possible disadvantages.

This is why there is nothing "new" about Thorazine (chlorpromazine, SK&F). This is why it remains the first choice in many conditions—and the standard against which other agents are inevitably compared.

This is why it is one of the fundamental drugs in medicine.

SMITH KLINE & FRENCH
LABORATORIES, PHILADELPHIA

SK&F



For comprehensive control of the whole pain complex... helps the whole patient

Like a triad, the action of Trancogesic is direct and simple as 1,2,3. Its tranquilaxant component — chlormezanone — 1. reduces emotional reaction to pain . . . 2. decreases skeletal muscle spasm . . . and 3. its aspirin component dims the patient's perception of pain. Thus, Trancogesic controls the *whole* pain complex, helps the *whole* patient — *with unsurpassed tolerance.*

Each tablet of Trancogesic contains 100 mg. of chlormezanone and 300 mg. (5 grains) of aspirin. The usual adult dosage is 2 tablets of Trancogesic three or four times daily; the dosage suggested for children from 5 to 12 years is 1 tablet three or four times daily. Reactions to Trancogesic have been minor — gastric distress, and an occasional weakness, sedation or dizziness. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. Trancogesic is contraindicated in persons known or suspected to have an idiosyncrasy to acetylsalicylic acid. WINTHROP LABORATORIES, NEW YORK 18, N. Y.

TRANCOGESIC*
CHLORMEZANONE with ASPIRIN

*TRADEMARK 100 MG. 300 MG.

Winthrop

-1778M

most effective in the obese diabetic...

Recent reports suggest...insulin and sulfonylureas may accelerate lipogenesis,[1-5]...serum "insulin" levels are often elevated in obese diabetics[2,3,6]... DBI (phenformin HCl) reduces high blood sugars, lowers elevated "insulin" levels, tends to reduce body weight toward normal.[1,3,7-9]

In the obese diabetic (ketoacidosis-resistant), use of phenformin HCl together with a proper diet: **A.** acts to reduce high blood sugar without increasing fat synthesis or weight gain. **B.** does not increase already elevated endogenous insulin levels; may, indeed, act to restore more normal insulin levels. **C.** favors reduction of weight towards normal.

In the ketoacidosis-resistant obese diabetic not amenable to diet alone, hypoglycemic phenformin HCl appears to help avoid weight gain or reduce adiposity, factors which otherwise tend to make blood sugar control more difficult and to increase the likelihood of complications. However, in the ketoacidosis-prone diabetic, insulin is still the essential hypoglycemic agent.



Summary: Indicated in stable adult diabetes, sulfonylurea failures and unstable diabetes. Gastrointestinal side effects occurring more often at higher dosage levels abate promptly upon dosage reduction or temporary withdrawal. Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis, and treated accordingly. Use with caution in severe liver disease. Not recommended without insulin in acute complications (acidosis, coma, infections, gangrene, surgery). Consult product brochure for full information.

Bibliography: 1. Williams, R. H.: Textbook of Endocrinology, Ed. 3, Saunders, Philadelphia, 1962, p. 610. 2. Gordon, E. S.: Metabolism 11:819, 1962. 3. Grodsky, G. M. et al.: Metabolism 12:278, 1963. 4. Sadow, H. S.: Metabolism 12:333, 1963. 5. West, K. M. and Tophoj, E.: Metabolism 10:689, 1961. 6. Yalow, R. S. and Berson, S. A.: Diabetes 9:254, 1960. 7. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 8. Weller, C. et al.: Metabolism 11:1134, 1962. 9. Radding, R. S. et al.: Metabolism 11:404, 1962.

tablets 25 mg. **timed-disintegration capsules 50 mg.**

DBI® **DBI-TD®**

BRAND OF PHENFORMIN HCl

U. S. VITAMIN & PHARMACEUTICAL CORP. 800 SECOND AVENUE NEW YORK, N.Y. 10017

2 new works of timely interest

READY JANUARY FROM SAUNDERS

A New Book! ATOMIC ENERGY ENCYCLOPEDIA IN THE LIFE SCIENCES

Edited by C. W. Shilling

Covers Applications and Effects of Atomic Energy in the Fields of Medicine, Biology, and Agriculture. Every Item Verified by Experts of the U.S. Atomic Energy Comm.

This is the information you'll find in this authoritative new information source: the effects of atomic radiation on living material; the uses of radiation and radioisotopes in medicine, agriculture and biology; scores of other peaceful uses of atomic energy. Topics range from treatment of cardiac disease with radioactive isotope iodine-131 to methods of radioactive waste disposal. More than 1200 alphabetically-arranged entries give you precise information on topics with wide application to clinical practice and research as well as on topics of general, scientific, educational and historic interest.

Dr. Shilling and his distinguished contributors have combined the features of a dictionary with those of an encyclopedia. You'll find definitions for hundreds of technical terms (*absorption coefficient—acute radiation syndrome—cascade shower—Cerenkov radiation—mev—phantom—strontium unit—zeuto—neutron therapy—etc.*) as well as articles of a page or more on such subjects as *Recovery from Irradiation—Treatment of Radiation Illness—Blast Biological Damage—Radioactive Dosimetry —etc.*

More than 260 helpful illustrations portray a diversity of topics: *Example of radioactive contamination of the food chain—Cutaway drawing of a medical research reactor—Types of cell damage associated with irradiation —Schematic representation of the optical systems of the light and electron microscopes—Typical device for linear scanning of the entire body—etc.*

In addition—98 tables list such information as: *Colloidal and Large Particle Radioisotopes for Medical Uses —Gastrointestinal Absorption of Radioisotopes—Maximum Permissible Total Body Burdens for Four Radionuclides—etc.*

Here is a volume you will turn to for precise answers to specific queries, as well as for fascinating browsing in rare leisure moments.

Editor and Major Contributor, CHARLES WESLEY SHILLING, M.D., D.Sc., Consultant to the United States Atomic Energy Commission; Deputy Director, Division of Biology and Medicine, USAEC, 1955-60. With the Assistance of MIRIAM TEED SHILLING, M.A. Prepared under the auspices of the Division of Technical Information, USAEC. 474 pages, 7¼" x 10¼", with 268 illustrations, 98 tables. About $10.50. *New—Ready January!*

A New Book! Gellis and Kagan's CURRENT PEDIATRIC THERAPY

Specific Details of Over 300 Treatments Tailored to the Special Needs of Young Patients

A New Biennial Volume! This uniquely helpful *Current Pediatric Therapy Volume* brings you the same type of specific therapeutic recommendations that users of *Current Therapy* have enjoyed for some 15 years—*but keyed directly to the treatment needs of children.* Dr. Sydney S. Gellis and Dr. Benjamin M. Kagan have edited this new work, which will be revised every two years. Contributions by over 200 leading authorities pinpoint therapeutic details for more than 300 diseases —from *Kwashiorkor* and *Protein Deficiency* to *Infantile Cortical Hyperostosis.*

All discussions are approached from the pediatric point of view, with dosages, diets, prescriptions, etc., written for infants and children, and broken down, where necessary, into age or weight groups. You will find specific advice on: *selection of proper antimicrobial agents for various types of pneumonia; use of methicillin and oxacillin in staphylococcic empyema; new dosage schedule for digitalis preparations administered to infants; detailed instructions for steroid therapy in leukemia; etc.*

Whether you need a diet for a phenylketonuric child, help on deciding the proper dosage of antiepileptic medication, or late information on immunization schedules, you'll find it spelled out in *Current Pediatric Therapy.*

A Biennial Volume. By 248 Leading Authorities. Edited by SYDNEY S. GELLIS, M.D., Professor of Pediatrics and Chairman of the Department of Pediatrics, Boston University School of Medicine; Director of Pediatrics, Boston City Hospital; and BENJAMIN M. KAGAN, M.D., Director, Department of Pediatrics, Cedars of Lebanon Hospital, Los Angeles; Clinical Professor of Pediatrics, University of California, Los Angeles. About 815 pages, 7⅛" x 10½". About $16.00. *New—Ready January, 1964!*

To Order Mail Coupon Below!

W. B. SAUNDERS COMPANY
West Washington Square, Philadelphia 5, Pa.

Please send when ready and bill me:

☐ *Atomic Energy Encyclopedia* . . . About $10.50
☐ *Current Pediatric Therapy* . . . . About $16.00

Name .....

Address .....

SJG 12-63



The insomniac



The tense, nervous patient



The heart-disease patient



The surgical patient



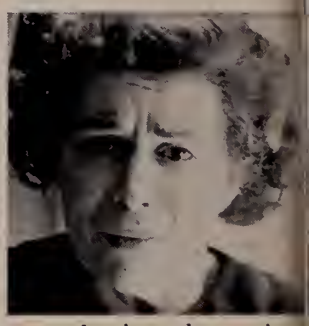
The girl with dermatosis



Tension headache



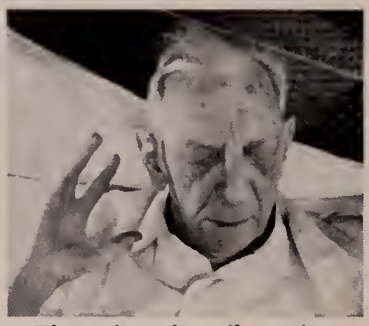
The woman in menopause



Anxious depression



Premenstrual tension



The agitated senile patient



The alcoholic



The problem child

the original brand of
meprobamate

Miltown®



The G.I. patient

WALLACE LABORATORIES
Cranbury, N.J.

The one tranquilizer that

BELONGS IN EVERY PRACTICE

it's versatile: The years have proved that 'Miltown' (meprobamate) is the one tranquilizer that is helpful in almost every aspect of daily practice. Virtually any of your patients, regardless of age, can be given the drug with confidence, either as a primary treatment or as an adjunct to other therapy. **Outstanding record of safety:** Over eight years of clinical use among millions of patients throughout the world — plus more than 1500 published reports covering the use of the drug in almost every field of medicine — support your prescriptions for 'Miltown' (meprobamate). This is why it *"belongs in every practice."*

dependable: 'Miltown' (meprobamate) is an established drug. There are no surprises in store for you or your patient. You can depend on it to help your patients through periods of emotional distress — and to help maintain their emotional stability.

easy to use: Because 'Miltown' (meprobamate) is compatible with almost any other kind of drug therapy, you'll find it fits in easily with any program of treatment you are now using. It will not, therefore, complicate treatment of patients seen in clinical practice.

BRIEF SUMMARY: *Indications:* Anxiety and tension states, and all conditions in which anxiety and tension are symptoms. *Side Effects:* Slight drowsiness may occur and, rarely, allergic or idiosyncratic reactions, generally developing after 1-4 doses of the drug. *Contraindications:* Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. *Precautions:* Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities, to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available to physicians on request.*

USUAL ADULT DOSAGE: 1 or 2 400 mg. tablets t.i.d.

SUPPLIED: 400 mg. scored tablets, 200 mg. coated tablets.

CM-9694

PROFESSIONAL LIABILITY INSURANCE PROGRAM

officially endorsed by

THE MEDICAL SOCIETY OF NEW JERSEY

PROTECTION for Professional Acts and Professional Premises Liability for members of The Medical Society of New Jersey by the First American Liability Insurance Company.

LOSS CONTROL. Your County Medical Review and Advisory Committee will evaluate malpractice cases and recommend the action which would be most favorable for the Medical Profession, the Defendant Doctor, the Patient and the Public. This program permits understanding of the complex problems involved in such cases and calls for close cooperation between the Medical Profession and Insurance Company.

MEDICO-LEGAL FORMS are furnished to each insured doctor to help in reducing claims or dissatisfied patients. Failure to use forms does not affect the doctor's insurance coverage or his eligibility for insurance.

INSURANCE COUNSELING. Insurance counseling and advice, available at all times, without cost, to help you with your Professional Liability insurance problems.

CANCELLATION. No policy will be cancelled or non-renewed without prior consultation between your Society and the Company and this is a matter of complete cooperation for the best interests of all concerned.

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY

Policies Guaranteed Non-assessable

Professional Liability Department

123 CLEVELAND STREET — ORANGE, NEW JERSEY

Joseph A. Britton, Manager — ORange 3-2575

Home Office: Wakefield, Mass.



(concentrates on coughs)

Tussicalm, by concentrating solely on cough relief, permits therapeutic and dosage flexibility in treating individual patients, since other symptoms may vary in type, frequency, onset and duration. Mixtures with multi-therapeutic effects may be unnecessary, increase danger of side effects, and result in "inadequate concentrations of effective ingredients...."[1]

With Tussicalm, patients receive concentrated 2-way action.

Noscapine—safe, effective cough suppressant.[2,3] Antitussive potency equal to codeine.[1,4-7] No addiction liability.[1,6,7] Wide margin of safety.[6-8] No opiate-like effects, such as constipation, respiratory depression or blood pressure changes.[5]

Glyceryl Guaiacolate—safe, superior expectorant. Greatly increases and thins bronchial secretions.[9] Facilitates elimination of sputum and soothes irritated bronchial mucosa.[10] Virtually no adverse effects.[9]

Tussicalm, being essentially free of side effects, is available to the whole family without prescription.

ROUSSEL CORPORATION, 155 E. 44 ST., N. Y. 17, N. Y.

ROUSSEL

Each teaspoonful (5 cc.) contains in a delightfully different tasting syrup: Noscapine 10 mg., Glyceryl Guaiacolate 90 mg., Citric Acid Anhydrous 75 mg., and Sodium Benzoate 5 mg. DOSAGE: *Adults:* 2 teaspoonfuls three or four times daily. *Children* (6 to 12): 1 teaspoonful three or four times daily. *Children* (4 to 6): ½ to 1 teaspoonful three or four times daily. SUPPLIED: 4 oz. bottles.

REFERENCES: (1) Bickerman, H. A.: M. Clin. N. America *45*:805, 1961. (2) Bickerman, H. A., & Barach, A. L.: Am. J. M. Sc. *228*:156, 1954. (3) Segal, M. S.; Goldstein, M. M., & Attinger, E. O.: Dis. Chest *32*:305, 1957. (4) Bickerman, H. A.; German, E.; Cohen, B. M., & Itkin, S. E.: Am. J. M. Sc. *234*:191, 1957. (5) New and Nonofficial Drugs, Evaluation by A.M.A. Council on Drugs, Philadelphia, J. B. Lippincott Company, 1962, p. 453. (6) Bickerman, H. A., *in* Modell, W., ed.: Drugs of Choice 1962-1963, St. Louis, The C. V. Mosby Company, 1962, p. 469. (7) Bickerman, H. A.: Clin. Pharmacol. & Therap. *3*:353 (May-June) 1962. (8) Winter, C. A., & Flataker, L.: Toxicol. & Appl. Pharmacol. *3*:96, 1961. (9) Bickerman, H. A., *in*

"Doctor... I'm so tired all the time"



Lethargic patients respond to Ritalin

(methylphenidate hydrochloride)

When lethargy is a medical problem—in convalescence, chronic fatigue, mild depression, menopause, oversedation, and senility, for example—the gentle stimulant action of Ritalin (methylphenidate hydrochloride) restores normal physical and mental activity.

In his report, Siegler[1] states: "In mild depression or in clinical exhaustion syndromes, a marginal sympathomimetic drug like methylphenidate seems to be the drug of choice for initiating therapy. It does not have the toxic effects found with the amphetamines or with the hydrazines or other antidepressants."

Other significant comments on the clinical safety of Ritalin (methylphenidate hydrochloride): "At no time was there evidence of serious toxic reactions [in a study of 185 patients]. The drug did not produce alteration in blood forming factors, kidney and liver function."[2]

"No significant toxic effects have resulted after the continuous administration of methylphenidate for more than 3 years."[3]

INDICATIONS: Chronic fatigue.

CONTRAINDICATIONS: Marked anxiety, tension, and agitation.

CAUTION: Should not be used to increase mental or physical capacities beyond normal limits. Use cautiously with epinephrine or levarterenol.

SIDE EFFECTS: Nervousness, insomnia, anorexia, nausea, dizziness, palpitations, headache, drowsiness.

DOSAGE: 10 to 20 mg. b.i.d. or t.i.d.

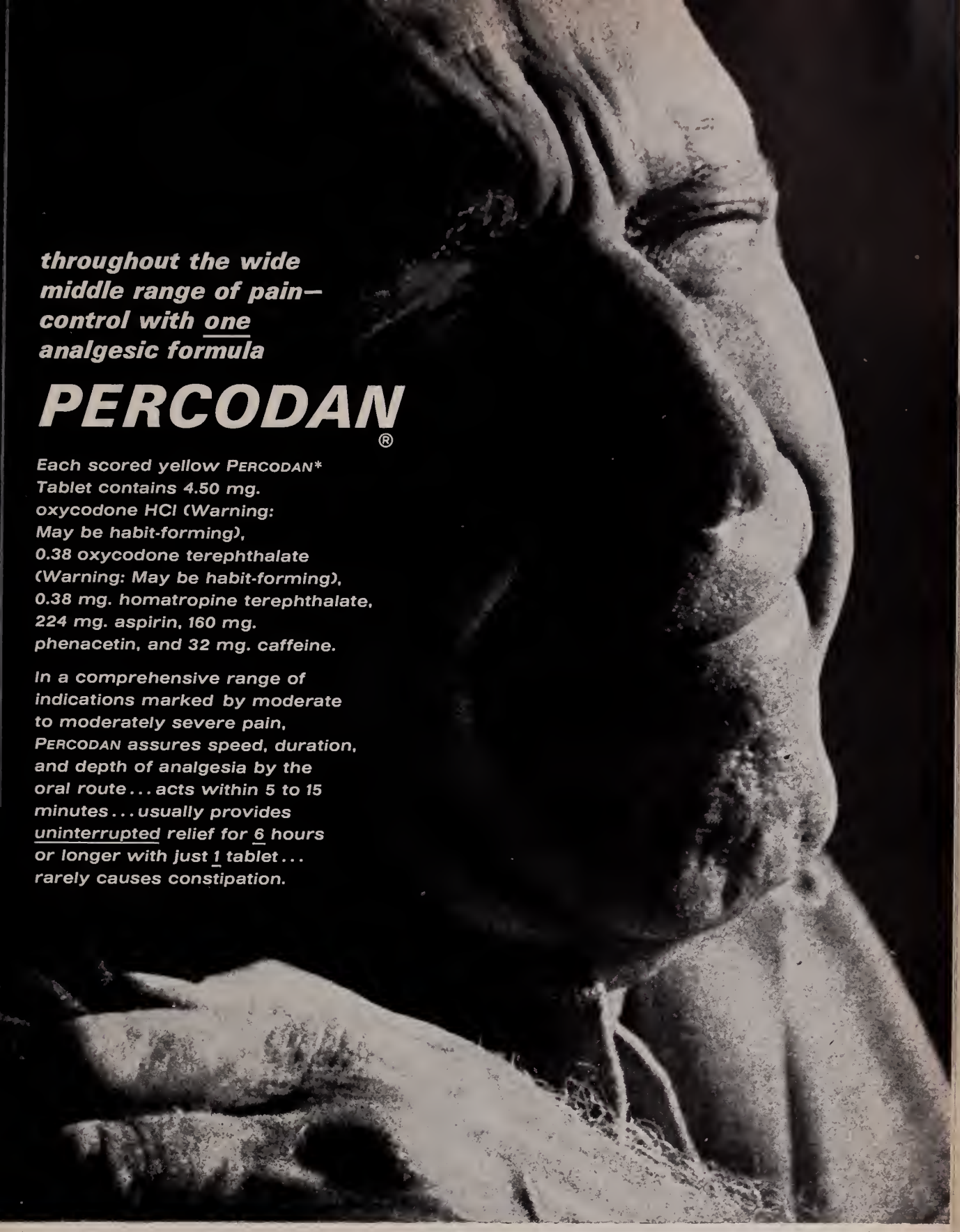
SUPPLIED: *Tablets*, 5 mg. (pale yellow), 10 mg. (pale blue) and 20 mg. (pale orange).

REFERENCES: 1. Siegler, P. E., in Nodine, J. H., and Moyer, J. H. (Editors): *Psychosomatic Medicine*, The First Hahnemann Symposium, Lea & Febiger, Philadelphia, 1962, p. 582. 2. Lapolla, A.: Western Med. 2:383 (Sept.) 1961. 3. Yoss, R. E., and Daly, D. D.: Pediatrics 25:1025 (June) 1960.

2/3098M8

C I B A SUMMIT, N. J.

Ritalin® hydrochloride (methylphenidate hydrochloride CIBA)



throughout the wide middle range of pain— control with one analgesic formula

PERCODAN®

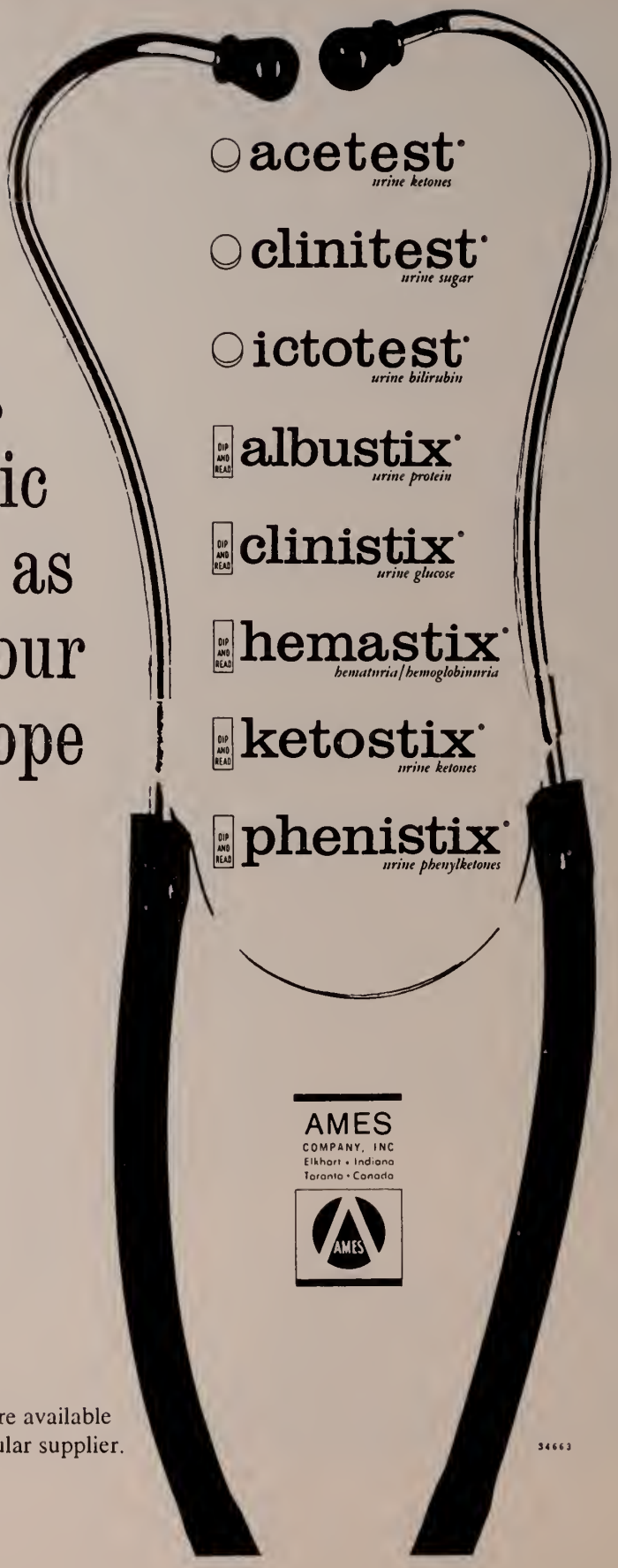
Each scored yellow PERCODAN* *Tablet contains 4.50 mg. oxycodone HCl (Warning: May be habit-forming), 0.38 oxycodone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.*

In a comprehensive range of indications marked by moderate to moderately severe pain, PERCODAN *assures speed, duration, and depth of analgesia by the oral route... acts within 5 to 15 minutes... usually provides uninterrupted relief for 6 hours or longer with just 1 tablet... rarely causes constipation.*

Average Adult Dose—1 tablet every 6 hours. **Precautions, Side Effects and Contraindications**—The habit-forming potentialities of Percodan are somewhat less than those of morphine and somewhat greater than those of codeine. The usual precautions should be observed as with other opiate analgesics. Although generally well tolerated, Percodan may cause nausea, emesis, or constipation in some patients. Percodan should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. **Also available:** Percodan®-Demi, containing the complete Percodan formula but with only half the amount of salts of oxycodone and homatropine. Both products are on oral Rx in all states where laws permit. Narcotic order required. **Literature on request,** **ENDO LABORATORIES Richmond Hill 18, New York**

Endo®

urine tests as basic as your stethoscope



acetest®
urine ketones

clinitest®
urine sugar

ictotest®
urine bilirubin

DIP AND READ albustix®
urine protein

DIP AND READ clinistix®
urine glucose

DIP AND READ hemastix®
hematuria/hemoglobinuria

DIP AND READ ketostix®
urine ketones

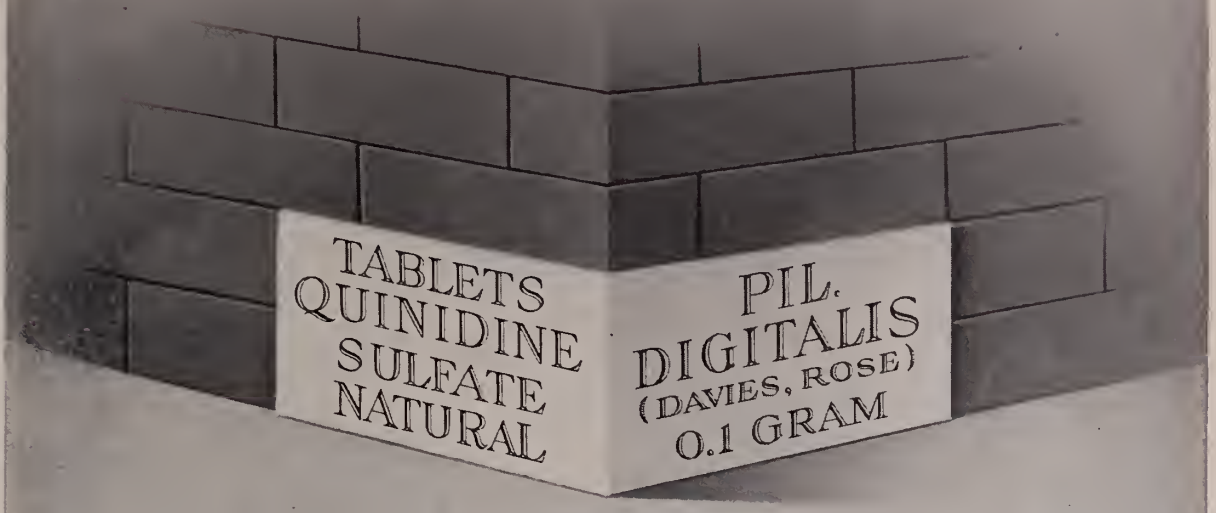
DIP AND READ phenistix®
urine phenylketones

AMES
COMPANY, INC
Elkhart • Indiana
Toronto • Canada

AMES products are available through your regular supplier.

34663

A CORNERSTONE OF CARDIAC THERAPY



The Dictionary defines a cornerstone as something of fundamental importance, just as Pil. Digitalis, (Davies, Rose) and Tablets Quinidine Sulfate Natural (Davies, Rose) are of fundamental importance in treating your cardiac patients. These preparations represent 60 years of experience and dependability in the manufacture of pharmaceuticals.

Pil. Digitalis (Davies, Rose), 0.1 Gram (approx. 1½ grains) which comprise the entire properties of the leaf, provide a dependable and effective means of digitalizing the cardiac patient, and of maintaining the necessary saturation.

Tablets Quinidine Sulfate Natural, 0.2 Gram (approx. 3 grains) are alkaloidally assayed and standardized, insuring uniformity and therapeutic dependability. Each tablet is scored for the convenient administration of half dosages.

Davies, Rose & Company, Limited - Boston 18, Mass.

DQ-2

COSMEDICAKE®

© 1963 Pat. Applied For

greaseless dehydrated lotion in
cake make-up form





3-way benefits
in acne, facial seborrhea

❶ antibacterial action
...to combat many common pathogenic skin microorganisms

❷ mild astringent and keratolytic efficacy
...to aid removal of excess sebaceous material and keratinization

❸ effective blemish concealment
...to help minimize emotional distress often occasioned by cosmetic defects

COSMEDICAKE is specially formulated as adjunctive therapy for skin eruptions of cosmetic importance in female patients. Extensive clinical experience confirms its 3-way benefits. In 88% of 112 female patients with acne vulgaris or acne rosacea, COSMEDICAKE produced results that were "cosmetically and therapeutically good"[1]—and no adverse effects were experienced. Its convenience and elegance achieve continued cooperation from grateful patients.

Applied with a damp sponge, COSMEDICAKE goes on the skin smoothly and uniformly as a reconstituted fast-drying lotion with no separation, no precipitation or uneven concentration. May be used morning and night...helps the patient gain confidence by improving her appearance while lesions are healing.

COSMEDICAKE contains hexachlorophene, benzalkonium chloride, salicylic acid, and colloidal sulfur in a smooth, greaseless, pharmaceutically elegant base.

4 skin-matching shades available at all pharmacies.

1. Berger, R. A.: Clinical Medicine, Sept. 1961.

also available:

COSMEDICAKE for Dry Skin—effective topical medication specially formulated for patients with dry skin...provides lipids for softening and moisturizing actions.

for samples
and complete literature write:

KAY PREPARATIONS COMPANY, INC.
345 West 58 St., New York, N.Y. 10019



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain... not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

WALLACE LABORATORIES / *Cranbury, N.J.*

CSO-9193

YOU CAN HAVE A

TAX EXEMPT INCOME

1—The interest received from Municipal Bonds is fully exempt from all present Federal Income Taxes, and is not reported on your tax return.

2—The safety factor of Municipal Bonds is second only to securities of the U. S. Government.

3—We presently have a special offering of general obligation Municipal Bonds, which will yield a 3.40 - 3:50% TAX EXEMPT return.

We would like to send you our chart, which illustrates the advantages of tax exempt income—it will show how much, depending on your income bracket, any given tax exempt yield will mean to you in taxable equivalent income.

Our booklet "The Story Behind Municipal Bonds" is also available at no charge upon request. After reading it, you will have a better understanding of the safeguards surrounding such bonds.

JOHN J. RYAN & CO.

STATE AND MUNICIPAL BONDS

790 BROAD STREET NEWARK, N. J.

Phone MI 3-8350

Tear off

PLEASE FORWARD TO ME

☐ Tax free vs. Taxable Bond chart.

☐ Booklet—"The Story Behind Municipal Bonds".

☐ Please send me your current offering sheet.



Notable increase in vigor, strength and sense of well-being

STROL (stanozolol-Winthrop), a heterocyclic steroid, combines nt anabolic effects with outstanding tolerance, stimulates appe- and promotes weight gain... restores a positive metabolic balance. ounteracts the catabolic effects of concomitant corticosteroid or H therapy. WINSTROL (stanozolol-Winthrop) rebuilds body tissue e it builds strength, confidence and a sense of well-being in con- ns associated with excess protein breakdown, insufficient protein ke and inadequate nitrogen and mineral retention.

Effects and Precautions: Prolonged administration can produce l hirsutism, acne or voice change. In an occasional patient, edema been observed and in young women the menstrual periods have n milder and shorter. These side effects are reversible, and pa- ts receiving prolonged treatment should be examined and ques- tioned periodically so that, should side effects appear, the dosage may be reduced or administration of the drug discontinued for a time In patients with impaired cardiac and renal function, there is the pos sibility of sodium and water retention. Liver function tests may revea an increase in bromsulphalein retention, particularly in elderly pa tients. In such cases, therapy should be discontinued. Although it has been used in patients with cancer of the prostate, its mild androgenic activity is considered by some investigators to be a contraindication

Dosage: Usual adult dose, 1 tablet t.i.d. before or with meals; young women, 1 tablet b.i.d.; children (school age): up to 1 tablet t.i.d.; chil dren (pre-school age): ½ tablet b.i.d. Available as scored tablets o 2 mg. in bottles of 100. For best results, administer with a high protein diet.

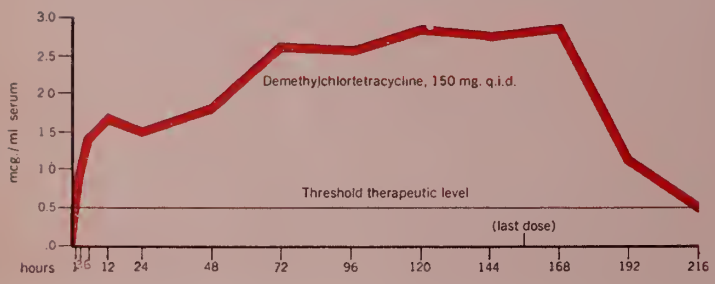
WINTHROP LABORATORIES, NEW YORK 18, N. Y

arked improvement in appetite / Measurable weight gain Winthrop

only 150 mg. versus 250 mg.

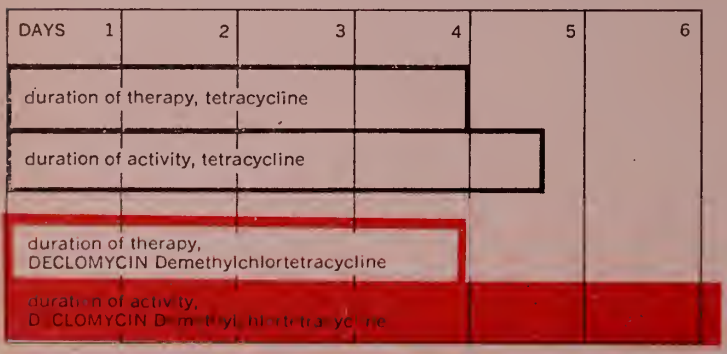


higher activity levels than other tetracyclines



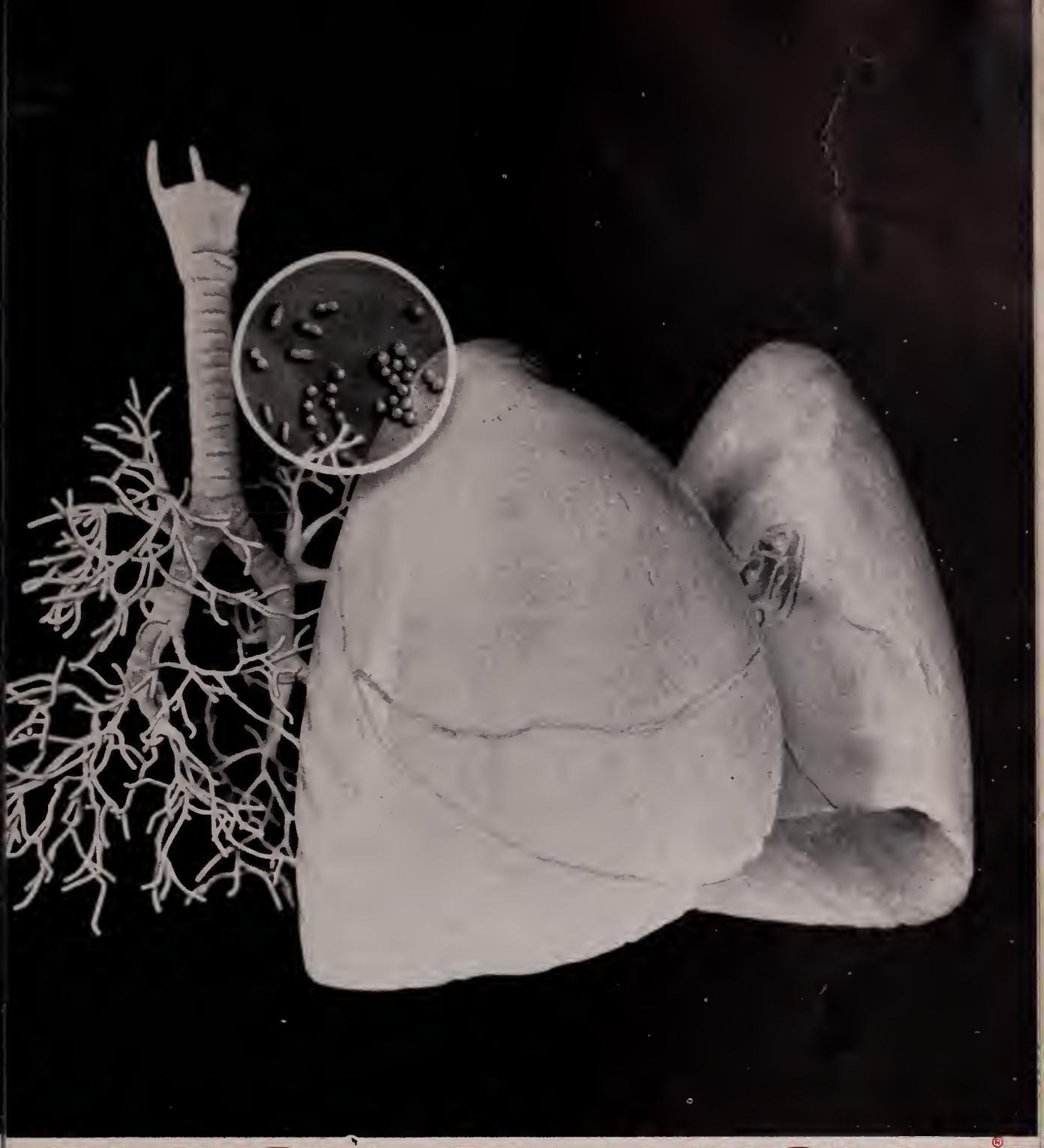
From Sweeney, W. M., Dornbush, A. C., and Hardy, S. M. *Amer. J. Med. Sci.* 243:296 (Mar.) 1962

1-2 days' "extra" activity





gives you an "extra dimension" of antibiotic control



DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE HCl

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. *Side Effects* typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. *Capsules,* 150 mg. and 75 mg. of demethylchlortetracyline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 b.i.d.

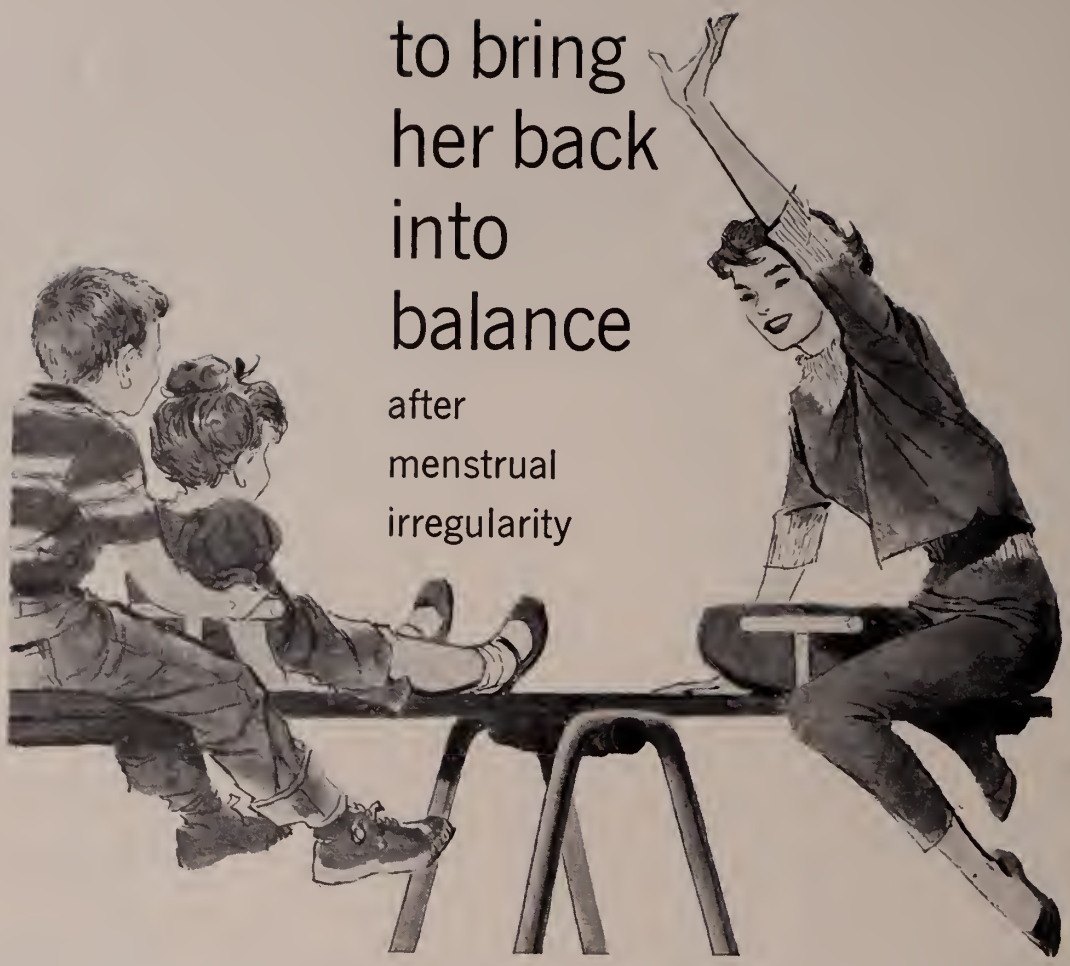
LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

7150-3

to bring her back into balance

after menstrual irregularity



an orally active progestogen-estrogen combination

Duosterone®

Ethisterone . . . 10.00 mg. Ethinyl estradiol . . . 0.01 mg. per tablet

Supplementing and supporting ovarian function, DUOSTERONE can help release your patients from the anxiety, discomfort and inconvenience of functional amenorrhea, dysmenorrhea, and dysfunctional uterine bleeding.

Periodic progestational treatment with DUOSTERONE aims at restoring the normal hormonal pattern of the secretory phase of the menstrual cycle, providing an orally active progestogen with an estrogen to prime the endometrium for adequate progestational response.

Dosage: Functional amenorrhea, 5 tablets daily for 5 days. Dysmenorrhea, 1 to 2 tablets daily during the second half of the menstrual cycle, except for the final two days. Dysfunctional uterine bleeding, 5 to 7 tablets daily for 5 days; in mild cases, reduce dose 1 tablet each day.

Side Effects: Ethinyl estradiol may occasionally cause headache, diarrhea, engorgement and tenderness of the breasts, nausea, vomiting, cramping, or skin rash. These side effects usually fade as the patient adjusts to the estrogen.

Cautions and Contraindications: DUOSTERONE is contraindicated in carcinoma of the breast and reproductive organs and should be used with caution in cases of known liver impairment.

Supplied: Bottles of 25 and 100 tablets.

ROUSSEL

Roussel Corporation
155 East 44th Street, New York 17, N.Y.

When you put patients on "special" fat diets..

you can assure them that no corn oil margarine is higher in polyunsaturates or lower in saturates than Mrs. Filbert's Corn Oil Margarine.

And once they've tried it, they can tell you that no margarine can match Mrs. Filbert's flavor.

Mrs. Filbert's Corn Oil Margarine is a special margarine* made from 100% corn oil, over 50% of which retains its liquid characteristics.

Of the total fatty acid content 28% is cis-cis linoleic acid. Ratio of polyunsaturates to saturates is about 1.7 to 1.

For additional information, including detailed listings of component characteristics, please write to us: J.H. Filbert, Inc., Baltimore 29, Maryland.



* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

We're now the 5th largest Blue Shield plan

Medical-Surgical Plan of New Jersey is now the fifth largest of all 71 Blue Shield Plans in the United States. The present enrollment of 2,372,000 members represents an increase of nearly 50,000 subscribers and dependents during the first half of 1963.

The Plan, naturally, is proud of the confidence thus demonstrated in it by New Jersey residents. The reason for such confidence should be a source of pride to the medical profession of New Jersey.

Blue Shield is only as good as its Participating Physicians make it. A Plan cannot grow steadily in membership, year after year, unless it is solidly based on wide and active participation by the profession.

Medical-Surgical Plan recognizes that it can successfully perform the functions entrusted to it by the medical profession—and continue to grow in stature—only with the continued cooperation and support of its Participating Physicians. To provide Blue Shield protection for more than one out of every three New Jersey residents is a challenge and a privilege shared by the Plan and the profession.

BLUE SHIELD®
MEDICAL-SURGICAL PLAN
OF NEW JERSEY
500 Broad Street, Newark





Smooths out emotional peaks and valleys

'Meprospan'-400 brand of meprobamate contains 400 mg. in sustained-release form. One capsule smooths out the anxious patient's emotional peaks and valleys for 10 to 12 hours — and provides these other advantages:

1. **Especially suitable for maintenance therapy.** Patients whose anxiety has diminished to a mild or moderate level still require a certain amount of tranquilization throughout the day. Sustained-release action is ideally suited to this type of patient.
2. **Simpler dosage schedule.** Since one capsule of 'Meprospan'-400 (meprobamate, sustained release) acts 10 to 12 hours, the patient enjoys a much simpler dosage schedule than with tablets — and is less likely to forget to take the medicine.

Side Effects: Rarely, skin reactions. May increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence in patients with history of drug or alcohol addiction.

Available: *'Meprospan'-400* (meprobamate, sustained release) contains meprobamate 400 mg. *'Meprospan'-200* (meprobamate, sustained release) contains meprobamate 200 mg. Both potencies in bottles of 30. **Usual dosage:** One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Meprospan®-400
meprobamate 400 mg.
sustained release

WALLACE LABORATORIES / *Cranbury, N.J.*

CME-9188



when aging brings anguish...

Leptinol

(Each bi-layer tablet contains: Pentylenetetrazol, 100 mg.; Niacin, 50 mg.; Thiamine Hydrochloride, 1 mg.; and Ascorbic Acid, 20 mg.)

Because geriatric patients compose an increasingly larger part of your medical practice, you see the problems of aging more often.

When one of your elderly patients displays the early warning signs of senile psychosis, prescribe Leptinol for safe, gentle relief from the symptoms—apathy, mental confusion, memory lapses.

Leptinol deters senile mental deterioration by stimulating the cerebral vasomotor and respiratory centers to affect a greater blood and oxygen supply to the brain and increased pulmonary ventilation.

Because no addiction or intolerance is introduced, you will also find Leptinol to be a welcome adjunct even to the treatment of slow degenerative diseases. Caution against overdosage, as Leptinol induces a sense of well-being.

DOSE: One or two tablets, three times daily. Write for descriptive literature and starter doses.

THE VALE CHEMICAL CO., INC.
Allentown, Pa.

VALE Pharmaceuticals since 1922

Introducing A New Sulfonamide

SULFABID
BRAND OF SULFAPHENAZOLE
A POTENT, LOW DOSAGE SULFONAMIDE DISTINGUISHED BY ITS INCREASED MARGIN OF SAFETY.



AN INCREASED MARGIN OF SAFETY. . .

The need for critical dosage adjustment to avoid toxic manifestations, is minimized when the sulfonamide chosen is SULFABID (brand of sulfaphenazole).

With SULFABID (sulfaphenazole), effective blood and plasma levels are achieved with a convenient twelve-hour dosage schedule, yet its urinary solubility and rate of excretion combine to provide a high degree of safety with minimal risk of excessive drug accumulation. In order to demonstrate this high degree of safety, Essellier and co-workers (1), personally took 25 grams daily for five days . . . over *six times* the recommended therapeutic maintenance dosage level without experiencing intolerance.

SULFABID (sulfaphenazole) has been critically evaluated in the treatment of thousands of patients throughout the western world, more than one-third of whom were infants and children. The results have established that SULFABID (sulfaphenazole) is well tolerated, and that in appropriate dosage it produces satisfactory therapeutic effects.

SULFABID (sulfaphenazole) is indicated in a wide variety of infections caused by sulfonamide—susceptible bacteria, ... Abscesses, Bronchitis, Cellulitis, Cystitis, Furunculosis, Otitis media, Pharyngitis, Prostatitis, Pyelonephritis, Sinusitis, Tonsillitis, Urethritis and wound infections.

An informative brochure . . . with clinical findings and bibliography is available from your Physicians Products Medical Service Representative or by mail request.

THESE CASE STATISTICS BASED UPON 33 PUBLISHED REPORTS OF THERAPEUTIC RESPONSE TO SULFABID * (Sulfaphenazole)

Indications	No. of Patients	Response* Recovered	None
Biliary tract infections	24	18	6
Bronchitis	233	190	21
Pharyngitis, laryngitis	185	155	16
Other upper respiratory infections	261	199	32
Dysentery, enteritis	49	46	3
Febrile abortion	39	32	7
Pelvic Inflammatory disease—adnexitis, endometritis, parametritis, etc.	523	484	6
Lymphadenitis, sinusitis	32	28	3
Otitis	159	116	16
Puerperal infections	140	54	55
Skin diseases—furunculosis, pyoderma, erysipelas, etc.	78	54	8
Surgical infections	206	199	7
Tonsillitis	125	122	1
Urogenital infections— prophylaxis	269	222	58
therapy	989	723	139
Miscellaneous	393	292	71
	3705	2934	449
		79%	12%

*9% unreported

(1) Essellier, A. F., H. Hunsiker and R. Goldsand; Ibid 88:813, 1958.

Contraindications

☐ SULFABID (Sulfaphenazole) is contraindicated in patients known to be sensitive to sulfonamides. Like most sulfonamides and certain other drugs, its use is also inadvisable in treating premature infants and in full-term infants for the first week of life due to underdeveloped enzyme systems and liver and renal function. For the same reasons, SULFABID (Sulfaphenazole) should be used with caution at term in pregnancy.

Precautions

While the reported incidence of reactions to SULFABID (Sulfaphenazole) is low, the usual precautions in sulfonamide therapy should be observed, including maintenance of adequate fluid intake. In the event of headache, nausea or vomiting, dosage should be reduced or discontinued; if urticaria, rash, fever or hematuria occur, the medication should be discontinued. When SULFABID (Sulfaphenazole) is used intermittently or for prolonged periods, blood counts should be performed regularly to detect the possible occurrence of blood dyscrasias. Administration of the drug should be stopped immediately if alterations are observed in the hematopoietic system. Patients with impaired renal function should be followed closely in order to avoid excessive drug accumulation.

Dosage:

SULFABID (Sulfaphenazole) is administered orally as tablets or as a suspension twice daily for five days or until the patient remains asymptomatic for 48 hours.

	Initial Dose	Every 12 Hrs. Thereafte
Adults:		
Moderate to severe infections—	2 tablets (1 gm.) or	
6 tablets (3 gm.) or	2 teaspoonfuls (10 cc.)	
2 tablespoonfuls (30 cc.) of Suspension	of Suspension	
Mild or urinary tract infections—	2 tablets (1 gm.) or	
4 tablets (2 gm.) or	2 teaspoonfuls (10 cc.)	
4 teaspoonfuls (20 cc.) of Suspension	of Suspension	
Children:		
30 mg./lb.	15 mg./lb.	
1 teaspoonful of Suspension or	½ teaspoonful of Suspension or	
1 tablet per 17 lbs.	½ tablet per 17 lbs.	

Incidence of Side Effects

In extensive clinical experience, the over-a incidence of side effects with SULFABID (Su faphenazole) has been low. Side effects wer mainly limited to complaints of stomach ups and nausea, and these were mild and short duration.

Supplied

*Tablets: 0.5 Gm., bottles of 50, 250, 100

*Suspension: 0.5 Gm. (500 mg) per 5 cc. (te spoon), bottles of 50 cc. (non-spillable, wi a dropper marked for ¼ and ½ teaspoo and 1 pint.

SULFABID
BRAND OF SULFAPHENAZOLE

PHYSICIANS PRODUCTS CO., INC.
PETERSBURG, VIRGINIA

ANNUAL CLINICAL CONFERENCE

Chicago Medical Society

MARCH 2, 3, 4 and 5, 1964

PALMER HOUSE, CHICAGO

LECTURES **TEACHING DEMONSTRATIONS**

MEDICAL COLOR TELECASTS **FILM LECTURES**

INSTRUCTIONAL COURSES

The CHICAGO MEDICAL SOCIETY ANNUAL CLINICAL CONFERENCE should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.

PARKWAY NURSING HOME



1201 PARKWAY AVE.
Trenton, N. J.
Tel. 882-6900

No Steps!
Ranch Type
New audio-visual
call system
from every patient
to Nurses.

One of New Jersey's newest, most modern and completely equipped Nursing and Convalescent Homes, catering to the Convalescent, Aged, and Chronically Ill. Private and Semi-private rooms.

- Referring physician has full medical privileges
- Complete 24-hour general nursing care
- Physical rehabilitation department
- Beauty parlor. Air-conditioned dining room, lounge, and lobby. Spacious patios.
- Ultra modern interiors with artistic color scheme
- Stainless steel kitchen tiled to ceiling
- Special diets. Planned social and recreational activities
- Residential section

REASONABLE RATES — YOUR INSPECTION INVITED

PARKWAY NURSING HOME

Registration Approved by American Hospital Association
Approved to Accept Blue Cross Patients
Member: Licensed Nursing Homes Assn. of N. J.
Member: American Nursing Home Association
Accredited as a skilled nursing home by the National Council of Accreditation for Nursing Homes
NEW JERSEY STATE LICENSED

blood, milk and Maalox®

(magnesium-aluminum hydroxide gel)

Practically standard treatment, now, for bleeding ulcer. Why is Maalox included? Antacid therapy *must* continue long after the wound has healed, and patients started on Maalox tend to stay on Maalox. It tastes good; it's effective and will not cause constipation—three important reasons for Maalox over the long haul. Some physicians, we are told, order Maalox routinely for hospital patients on drugs which could irritate. They feel it reduces the likelihood of gastric discomfort. Supplied: Suspension; Tablets No. 1; Tablets No. 2. (Each Maalox No. 1 Tablet is equivalent to 1 teaspoonful and each Maalox No. 2 Tablet is equivalent to 2 teaspoonfuls of Suspension.)



RORER

WILLIAM H. RORER, INC., FORT WASHINGTON, PA.



Protects your angina patient better than vasodilators alone

'Miltrate' contains both pentaerythritol tetranitrate, which dilates the patient's coronary arteries, and meprobamate, which relieves his anxiety about his condition. Thus 'Miltrate' protects your angina patient better than vasodilators alone.

Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

Dosage: 1 or 2 tablets *before meals* and at bedtime. Individualization required.
Supplied: Bottles of 50 tablets.

CML-9646

Miltrate®

meprobamate 200 mg.+ pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem.

KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.



KOAGAMIN®

parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenol 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

CHATHAM PHARMACEUTICALS, INC.
Newark 2, New Jersey
Distributed in Canada by Austin Laboratories, Ltd. • Paris, Ontario

Schering

The turning point for effective cold relief

Coricidin®

The most widely used ethical cold preparation in America.

Each CORICIDIN Tablet contains: CHLOR-TRIMETON® (chlorpheniramine) Maleate, 2 mg., aspirin 0.23 Gm., phenacetin 0.16 Gm., caffeine 0.03 Gm. Each CORICIDIN "D" Tablet contains phenylephrine 10 mg. in addition to the above ingredients. CORICIDIN Tablets, brand of antihistaminic-antipyretic-analgesic compound.

S-227R





Empty capsules are filled by the finest precision machinery available . . . but no machine is perfect. That's why all Lilly Pulvules® (filled capsules) are given the "thirty-minute checkup" to be certain that uniformity is maintained. At least once every thirty minutes ten filled capsules are taken from each machine and carefully weighed on a prescription balance. In addition, the checks are double-checked at least four times each day . . . another of the many stringent controls which assure you that the Lilly products you prescribe provide quality that merits the full measure of your confidence.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

300680

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

The TB and Health Association: The Doctors' Ally

Not all physicians are enchanted by the activities of the voluntary health associations. However, one of the old-timers in the field, the Tuberculosis and Health Association, is an agency that has always stressed the "see your doctor" motif. Actually, some of the patients who come to the family physician with chronic cough or dyspnea were, in effect, motivated by the educational work of the New Jersey Tuberculosis and Health Association. This Christmas Seal agency will, for the second successive year, distribute through all the mass media the message: "If you have shortness of breath or a chronic cough, you may have a respiratory disease. Don't take chances. See your doctor."

The control and eradication of tuberculosis cannot be divorced from the control of other respiratory diseases. If persons with chronic cough or shortness of breath can be motivated to see their physician, some previously unknown cases of tuberculosis will be discovered. So will other chest diseases. Physicians will use a multiplicity of diagnostic tools, including tuberculin.

The examining of increasing numbers of persons with symptoms of respiratory diseases will demonstrate any local needs for facilities for the diagnostic, evaluation, treatment, and rehabilitation of persons with chronic respiratory disease.

In this respect also the tuberculosis and health associations are at work. At the Hospital Center, Christmas Seal dollars have been put into the development of a pulmonary rehabilitation program, an out-of-hospital basis. Services include: *Diagnostic Evaluations* (medical examinations, physical medicine examinations, pulmonary function testing, evaluation of vocational potential), *Medical Care and Treatment* (continued medical supervision, appropriate medications, treatment of related conditions, supervision of daily living activities, inhalation therapy), *Physical Medi-*

Published Monthly Since 1904 Henry A. Davidson, M.D., Editor
Under the Direction of the Committee on Publication Theresa E. Goeke, Assistant Editor
George B. Sharbaugh, M.D., Chairman
Place of Printing and Mailing — 116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton, N. J.
Send all communications for publication to P.O. Box 904, Trenton, N. J. 08605—EX 4-3154
Send all communications regarding advertising to Joseph W. Cookson, 370 Morris Ave., Trenton, New Jersey 08611 — EX 3-7196
Each member of the Society is entitled to receive a copy of The Journal every month
Whole Number of Issues 712

Vol. 60, No. 12 DECEMBER, 1963 50 Cents - $5.00 per year

cine (postural drainage exercises, pursed lip breathing exercises, diaphragmatic breathing exercises, abdominal muscles exercises, breathing exercises), and *Rehabilitation Services* (physical therapy, occupational therapy, prevocational evaluation, speech therapy, activities of daily living, social service).

Referrals are invited to this exciting program which will demonstrate the value and adaptability of similar, on-going services in other areas of New Jersey.

These twin approaches of educating the public to the importance of symptoms and of demonstrating a needed service are in the best traditions of the voluntary agency. In them we are once again reminded of the ally we have in the Christmas Seal, which helps us fight tuberculosis and other respiratory diseases.

Our Half Century With the O.P.C.

This is the last issue of THE JOURNAL to be printed by the Orange Publishing Company. We are old friends; and as with all old friends, parting is something of a sorrow. The Orange Publishing Company is the only printer that this JOURNAL has ever known. Volume 1, number 1, came out in 1904, and it was the O.P.C. which printed it. They have printed every issue since.

Under the name of 'Orange Printing Company", the firm was founded by Frederick M. Hill in 1903. The present name ("Publishing" rather than "Printing Company") was adopted in 1908. In that year, Frederick Hill's son, Roy, joined the company, learned the trade, got his printer's card. While others, at various time, had major stock interests, a Hill remained as general manager through three generations — Frederick, Roy and Lester. Lester Hill and Joseph Bleakley became full owners of O.P.C. in 1952.

In its time, O.P.C. published three local newspapers. On its presses were printed the *Railroad Employee*, one of the largest trade union magazines in the country. Several medical organizations still use the O.P.C., including our component Essex County Medical Society. And for many years, it did all the printing for The Medical Society of New Jersey—stationery, Annual Meeting programs and special pamphlets.

But now, the Society has found it best to concentrate all its executive and editorial functions in Trenton. Thus it became advisable to seek a printer in that area. There was need, too, for a larger company, one with presses capable of doing swift multi-colored printing, with its own binding, mailing and art departments. It was part of the same spirit of change that has caused the corner grocer to go to work in a supermarket; that has replaced the solo doctor and his little black bag with the complex accoutrements of modern practice. Expanding medical society activities, together with concentration of functions in the headquarters city, led the Trustees to select the Hibbert Company in Trenton as the Society's new printers. You will see their first production with the January 1964 issue.

The change is a sign of progress—an occasion for congratulations: yet an occasion for sadness, too. The Orange Publishing Company has been with us for more than a half century. In that time, its printers and managers have learned to know us well. They have become familiar with our personnel, our quirks, our organizational structure, and even the odd spellings of some of our odd names. Our relationship with the small staff of O.P.C. was a kind of homely family tie—as is possible with small and friendly organizations. Hence, this tincture of sorrow in the severance of the tie. No one likes to turn his back on an old friend.

We make our adieu to the Orange Publishing Company, and with them we send to the Company the wishes of all the Society for their continued success in northern New Jersey's printing field: an area they have so well adorned since 1903.

PAUL B. FERRARY, M.D.

Paterson

Continuing Education for the Physician

The distinction between knowledge or wisdom on one hand, and skill or craftmanship on the other, are here interestingly presented by Dr. Ferrary.

If you are seeking a better view through a scope, an advanced method for extirpating an ulcerated pylorus, a newer program of antibiotic therapy, read no further.

Loose usage has made us equate technologic refinements with education. Such sharpening of skills is better classed as training. *Training* is a narrowing, or specializing process, *education* a broadening, or understanding process.

Education is not the pursuit of facts or methods. These are listed and can be at everyone's fingertips at a moment's notice. Rather, education is an extended and continuous stimulation of the intellect—resulting in gradual deepening of insights, imagery, and ideation. That no immediate utilitarian purpose is served need be of no concern. The eventual enrichment of the individual inevitably will permeate his every activity and relationship.

The public attitude toward medicine is swinging away from the concept that we are a learned profession to a critical qualified acceptance of medicine as a high-priced *prima donna* technology. The shrewd interpretation by native intelligence shows clearly here, for public opinion has much truth on its side.

In narrowing down to technologic excellence, the individual physician and the profession generally have turned their backs on many of the qualities which make for a learned profession. The constant chase after what *can be done* at the expense of learning what *should be done* is casting an ever-lengthening shadow over the medical profession. It fosters alienation of many without and some within.

Besides learning more and more about less and less ("How to," or specialization) the profession needs to hold it at once an obligation and a privilege to learn more and more about more and more—"Why?" or generalization.

The day of the 18th century gentleman-scholar-philosopher-statesman-scientist has long since passed. No longer can one individual encompass all of man's learning with any semblance of competence. At the same time there is no excuse for, nor need of a specialization which isolates and insulates from the mainstream of life. Superspecialization narrows down to the ludicrous point at which one can communicate only with those similarly superspecialized. This smacks too much of the anthill or beehive. There the few males are kept only for studs, the one sexually competent female for a larva factory, and the remainder virtually sexless—indistinguishable one from the other—ever-busy and never taking a real look at the product of all the industry.

Sir William Osler repeatedly admonished the physician to be a well-read and well-rounded man. But today it is rare to find any of solid influence within the profession who raise their voices for like advice.

The educated man may be said to be capable of making a critical evaluation of contempo-

rary life. In the medical man this calls for more than knowing that one's specialty is good and useful, or knowing that taxes are too high, or knowing that foreign competition is ruining this or that industry, or knowing that "they" should stop trying to "socialize" us, or knowing that the surgeons (or physicians) are trying to stultify us physicians (or surgeons) by devising a surgical (or medical) procedure which is successfully treating a former medical (or surgical) condition. Actually, to make a critical evaluation of contemporary life, one should be in sympathetic contact (even if only on the level of the dilettante) with the arts, literature, natural and physical sciences, the behavioral sciences, history and philosophy. To confine one's learning activity to one's immediate profession wastes much of the potential of the man in the exclusive pursuit of a constantly diminishing return. To acquire a given bit of information may have taken ten minutes at the beginning of one's training; but after ten years to learn the same amount might take ten weeks of wading through much already-learned material to find the worthwhile new kernel!

Carrying a burden of this magnitude makes for dull plodding. A new spring will come into the pace by cutting down strictly professional reading to 50 per cent of the reading time and filling in the rest with a variety of stimulating research in other fields. Not only will horizons begin to spread out, but a new depth of personal purpose will develop, as will innumerable opportunities for application of the fresh attitudes in professional and other matters.

Any branch of learning fits in with all aspects of professional endeavor. Try philosophy in an attempt to orient your aims with or against the great thinkers. At the same time discover the antiquity of many "modern" ideas. History is all-encompassing. Today becomes somewhat less puzzling as familiarity with the repetitious but ever-changing past grows. The arts and literature need no apology from me. Their rich variety has something for everyone who will but look.

Overlapping medical studies, requiring almost no adjustment for the practitioner, are the behavioral sciences; psychology, anthropology, and sociology. These deal with facets of mankind which will add a new dimension to anatomy, physiology, pathology, diagnosis and treatment. They study man, who and what he is. They help show us how he got that way, and maybe where he might expect to go. Their literature is deeply interdependent, and much of it is not highly technical. They serve as a springboard into many related but surprising fields, as curiosity impels the reader to go on to economics, mythology, history, archeology and paleontology, geography, evolution, history of religions, and virtually the whole panorama of knowledge over recorded and prehistoric times.

Additions to the private library, access to the public library, borrowing from and lending to trustworthy parties all help in the enrichment. Scanning book reviews can be time-saving in skimming a work one will not care to peruse in its entirety. Reviewing the reviews is also helpful in determining which books should be obtained for partial or complete reading.

A journal or two from fields other than medicine will help broaden one's interests. Current favorites of my own include *Science,* the journal of the American Association for the Advancement of Science. This contains long and short articles, news items and comment, and excellent book reviews. All sciences are represented. Most of the material is intelligible to any reader possessing some scientific background. Another is *Daedalus,* the quarterly of the American Academy of Arts and Sciences, featuring symposia on a wide variety of topics. Many others exist, and selection will be determined by individual tastes.

For those who feel achievement through activity in preference to sedentary study—arts, crafts, hobbies and sports can open up unexpected educational opportunities. Boating might lead to study of design, propulsion, cartography, meteorology, astronomy, and magnetic forces. Building a wall might stimulate research on materials, surveying, drainage, even speculation on the problem of whether

the mortar holds the bricks together or apart! Similarly interests in photography, golf, gardening, chess, or any other avocation can lead to many crisscrossing byways where the traveling is always pleasant and never lonely.

The student will begin to note progress as cocksure confidence begins to give way to thoughtful uncertainty. The dependence stage of true addiction will have been reached when he feels himself slipping farther back into ignorance as each door unlocked reveals several more which have to be unlocked.

Just as one never really becomes a philosopher, one never really becomes an educated man—or are they the same thing? Every man worth his salt, however, should die trying!

80 Park Avenue

Psychosomatic Profile • • •

Psychogenic Causes of Hypersomnia

In the diagnosis of hypersomnic states one should differentiate narcolepsy from other causes. Narcolepsy consists of short periods of sleep. The diagnosis is certain when the following tetrad is present: (1) short episodes of sleep, (2) attacks of cataplexy (brief loss of muscle tone), (3) sleep paralysis (inability to move upon awakening), (4) sleep hallucinosis (vivid visual hallucinations). In addition to causes such as lesion of the third ventricle, encephalitis, head trauma and hypothalamic lesions, narcolepsy [1] may be due "to deep seated emotional trauma." Strong aggressive, hostile emotions have been described by several authorities [2] as factors in narcoleptic and cataplectic attacks. Long periods of sleep which may last for hours, days and weeks have been described [3] under the name of psychogenic hypersomnia. Electroencephalographic studies revealed, however, that during part of the prolonged episodes of sleep the patients may be awake but in a state of "hysterical trance." In the cases [3] described by these authors, attacks of sleep were also provoked by strong hostile emotions as well as by a need to avoid unpleasant situations. One of my recent patients, resentful of her duties as mother and housewife, constantly feels "tired, bored and unhappy." She falls asleep whenever the occasion presents itself. She says that she falls asleep to avoid "things I have to do in the house." A 15-year old boy yawned and seemed sleepy when I interviewed him. I could not get away from the impression that there was contempt and hostility behind this behavior. He said he fell asleep whenever he felt angry. A 17-year old with the typical tetrad of narcolepsy had his first attack after repressing anger against his teacher. He told me, "I hate the world around me. At times I feel like beating twenty kids up." One frequently encounters people yawning or falling asleep in company or in inappropriate places. Hostility and contempt can be frequently elicited in these cases even by a casual non-psychiatric observer.

Eugene Revitch, M.D.

---

1. Wechsler, Israel: Textbook of Neurology. Philadelphia, 1958, Saunders. Ed. 8. Page 598.
2. Langworthy, O. and Betz, B.: Psychosomatic Medicine, 6:211 (Feb. 1944); *Also,* Smith, C. and Hamilton, J.: Psychosomatic Medicine, 21:40 (January 1959); *and* Levin, Max: American Journal of Psychiatry, 116:139 (July 1959).
3. Smith, C. M.: Archives of Neurology and Psychiatry, 80:619 (June 1958); *and* Goldstein, N. P. and Griffin, M. E.: American Journal of Psychiatry, 115:929 (Sept. 1963).

William J. Follette, M.D.

Englewood

Lump in the Neck*

A mass in the neck is a diagnostic and therapeutic challenge. Dr. Follette here offers a ready reference schema of management.

A lump or mass in the neck presents an interesting, and not infrequently, a complex and difficult diagnostic exercise. The lump may be classified in a variety of ways. Is it a solid or cystic mass? benign or malignant? primary or metastatic? child or adult? It may be classed also by organ system.

While it is important to make a diagnosis, I must caution against the tendency to immediate incisional biopsy. This should be the last procedure, done after everything else has failed. Why? (1) Any unilateral enlargement of a cervical lymph node in the adult is almost always cancerous, usually metastatic from a primary lesion in the mouth, nasopharynx, pharynx, larynx or hypopharynx. (2) Incisional biopsy can produce seeding with the likelihood of recurrence. (3) Incisional biopsy can be dangerous to surrounding nerves and other essential structures. (4) Incisional biopsy frequently makes for a more difficult definitive secondary excision.

HISTORY

The patient's complaints should be taken at face value. Questions should include: (a) How did you notice it? (b) How long have you had it? (c) Has it grown? (d) Is it painful? (e) Does food "stick" when you swallow? (f) Is there regurgitation of food into the mouth after eating? (g) Has there been any hoarseness? (h) Has there been any earache or sensation of blockage of the ear? (i) Has there been any bleeding? (j) Has there been any nasal obstruction? (k) Any weight loss? (l) Any change or absence of sensation anywhere in the body? (m) Do you smoke? (n) Do you drink? (o) Any change in vision? (p) Any headache? (q) Any fluctuation in size, and if so, when?

EXTERNAL INSPECTION

The following scheme of inspection is suggested: (1) Location. (2) Size in centimeters. (3) Color. (4) Shape and configuration. (5) Evidence of drainage. (6) Involvement of other structures such as a Horner's syndrome, or involvement of the various cranial nerves.

INTERNAL INSPECTION

A survey is made of the entire oral cavity with any dentures removed; the entire tongue, including its motility; the nose, throat, palate, pharynx, nasopharynx, larynx, hypopharynx, and ears. The doctor's equipment must include as a minimum, tongue depressors; several sizes of angulated mirrors; a palate

*Read February 22, 1963 at the American College of Surgeons meeting in San Juan, Puerto Rico.

retractor; an electric nasopharyngoscope; and a Yankauer "boot" speculum.

PALPATION

Externally: (1) Is it tender? (2) Is it hard, soft, or fluctuant? (3) Fixed or mobile? (4) Does it move on swallowing? (5) Are there any pulsations? (6) Is it single or multilobular?

Internally, palpation is extremely important but frequently neglected. Using a glove or finger cot, palpate the mouth including the floor of the mouth, the alveolus, tongue (including base), the hypopharynx, and the nasopharynx.

AUSCULTATION

AUSCULTATION may be helpful in differentiating lesions such as arteriovenous aneurysm, and other vascular masses.

BIOPSY

IF A primary lesion is visable, take the biopsy with small cup or biting forceps. This can usually be done without benefit of anesthesia. If no primary lesion is seen, multiple small biopsies are taken with cup forceps, including the nasopharynx and pharynx (Waldeyer's Ring). Aspiration biopsy may be valuable, but its accuracy of diagnosis is in direct proportion to the experience and perseverance of the pathologist. Such a biopsy may determine cystic contents (*i.e.*: abscess, branchial cyst, etc). It may produce a solid plug of tissue for histologic sections. It can be used for a smear for Papanicolaou staining, or for routine stain. It may make possible a cell block of the aspirated fluid or a culture.

SPECIAL TESTS

THE following should be considered:

(a) X-ray of chest. (b) X-ray of soft tissues of neck. (c) Esophagram. (d) Laryngogram. (e) Blood count. (f) Radioactive iodine studies with scanning. (g) Bone marrow studies. (h) Endoscopic examination of the larynx, esophagus, trachea, and bronchi. (i) Complete medical work-up of other systems such as the gastro-intestinal, genito-urinary, the uterus or kidneys.

If these have failed to provide a diagnosis, then it may be necessary to perform surgical exploration with frozen section or, finally, an incisional biopsy.

TREATMENT OF BENIGN MASSES

TOTAL excision of the mass is suggested providing an essential structure is not compromised or sacrificed. Another possibility is total excision plus partial excision of host organ with parotid gland, a superficial lobectomy is the usual procedure. With a thyroid adenoma, lobectomy or subtotal thyroidectomy is usually done.

MALIGNANT MASSES

THE surgeon should eradicate the primary lesion by surgery, radiation therapy, or by combined therapy. He should excise metastases, preferably, in continuity with the primary lesion, and perform immediate or prepare for delayed reconstructive and rehabilitative surgery.

In lymphoma, consider radiotherapy, possibly with chemotherapy too.

The patient may require composite operations including a radical neck dissection, excision of a portion of the mandible, floor of the mouth and tongue. In malignant *thyroid* lesions, consider lobectomy, or total thyroidectomy if malignancy is of low grade. Radical neck dissection or modified radical neck dissection is considered in the presence of gross lymph nodes. Total thyrodiectomy is recommended in continuity with radical neck dissection for higher malignancy. It may be necessary to follow this with radiotherapy and radioactive iodine.

In low grade *Parotid* gland malignancies limited to the lateral lobe, a superficial lobec-

tomy may suffice. In high-grade malignancy, a total parotidectomy including excision of the facial nerve, and radical neck dissection may be required. If the nerve is sacrificed, an attempt is usually made to restore motor function to the face by means of either a hypoglossal nerve crossing, or a nerve graft utilizing the greater auricular nerve.

SUMMARY

WHEN a doctor has a patient with a mass in the neck, the fundamentals of physical diagnosis must be applied. Detailed history, inspection, palpation, auscultation, and various special tests should be utilized. The surgeon should rely upon incisional biopsy only as a last resort after all other tests and examinations have been done.

Treatment includes complete excision of benign tumors and cysts without sacrificing essential structures or compromising the patient from a cosmetic standpoint. Malignant lesions must be complete and radically removed whether by extensive surgery, radiation therapy, chemotherapy, or by various combinations of these.

214 Engle Street

Serendipity in Drug Research

Everybody who talks about the products of the future should admit that he doesn't know what he's talking about. We do not know—and in some ways can't even imagine—what will turn up . . . Drug research today doesn't proceed in a straightforward line from the discovery of the cause of a disease to the discovery of a treatment. Instead, scientists experiment with a broad range of related chemicals, and chemicals related to the related chemicals. Some of the greatest breakthroughs were found while working on something else. The new diuretics, for example, came while looking for a way to keep the kidneys from excreting penicillin too rapidly.—Walter A. Munns, President, Smith Kline & French Laboratories, to New York Society of Security Analysts.

Study of Cooley's Anemia

Your cooperation is requested in the referral of patients with thalassemia major (Mediterranean anemia or Cooley's anemia) for a continuing study in progress at the National Institute of Health, Bethesda, Maryland.

Patients who have not received transfusions within one month prior to admission here are preferred. However, they will receive transfusions at the Clinical Center if needed. Children patients must be over 5 years of age.

Hospitalization for two weeks should be anticipated for the required studies. Upon completion of their study, patients will be returned to their referring physicians, who will receive a complete narrative summary and report of our findings.

Physicians interested in having their patients considered for admission to this study may write or telephone:

Dr. Sherman M. Weissman
Office of Intramural Research
National Cancer Institute
Bethesda, Maryland 20014
Telephone: 49-63130 (Area code 301)

V. Terrell Davis, M.D.†

Trenton

Institutionalization of Infants

In their eagnerness to spare the parents added griefs, doctors too often urge swift, sometimes immediate institutionalization of retarded or severely handicapped newborns.

It is not possible to make progress without creating new problems. Our progress in the development of institutional facilities for infants has developed in its wake the problem of defining rather clearly and specifically the circumstances under which the use of these facilities is in the interest of the infant. Dangers inherent in the ill-advised use of these facilities should be clearly indicated.

Institutions for the mentally retarded were originally established as "asylums," and in most instances individuals who could no longer be cared for in the community were placed in those institutions for life. More recently we have begun to see these facilities as offering specialized care and training which could not be provided in a non-residential setting. Such services may be necessary for only a temporary period. Only in recent years have special facilities been provided in state institutions for the chronic care of infants with serious disabilities. Prior to this extension of our institutional program, there were no such facilities available for infants and the problem of assessing the appropriateness of such a placement did not exist.

There is probably not an expectant mother or father who at some time has not had at least a fleeting anxiety over the possibility of their child being born with a physical or mental defect. There are few chores more painful to a physician than that of advising a mother that her child has a serious defect and of counselling with her and the father as to the handling of this situation.

In such difficulty there is the ever present temptation to take an easy expedient and hope that the future implications of the problem will not materialize. There is also the very natural tendency to displace the real concern and anxiety from the current painful situation and focus it on an anticipated or imagined situation in the future. Perhaps it is this latter tendency which has lead some physicians to focus their concern on the mother's problem of placing a child in an institution some years after birth and to suggest that this difficult decision can be avoided by immediate institutionalization of the newborn mentally retarded infant without the mother having had an opportunity to develop a natural and normal attachment to the child.

Drs. Slobody and Scanlan* of the New York Medical College (Flower and Fifth Avenue Hospitals provided a real service to the practicing physician in analyzing in frank, clear and simple language "the consequences of early institutionalization mental retardation." They state: "Early placement of the retarded child in an institution (although it often may seem the expedient method of dealing with the problem) far too often has un-

†Dr. Davis is Director of Mental Health and Hospitals within our State Department of Institutions and Agencies.

*American Journal of Mental Deficiency, May 1959.

foreseen and disastrous consequences for the child and the family. Its further possible consequences, in terms of the relationship between the family and the physician who advises it, are obvious."

They also indicate that their experiences support the recommendations of the expert committee on the mentally sub-normal child of the World Health Organization and the W.H.O. Technical Report (Series No. 75 of April, 1954) to the effect that (a) *home care of the retarded is to be advised unless serious problems will arise as a result of it;* (b) *even severely handicapped children can be cared for at home by parents of reasonable mental health* and competence with the help of available community facilities; (c) the best institution is no substitute for the parent-child relationships; and (d) that early placement often intensifies parental guilt feelings and their sense of having rejected the child.

Should the mother of a mongoloid child be taken into the confidence of the father and the attending physician in determining whether the newborn should be taken home or whether placement in an institution should be made without the mother seeing the child and determining for herself whether she could care for it? It is the prerogative of the male to be chivalrous; but we must ask if it is chivalrous to deny a woman the pain, as well as the privilege, of making a decision which concerns her more than anyone else.

The New Jersey Department of Institutions and Agencies operates a nursery at the North Jersey Training School for Girls at Totowa, N. J. This nursery is geared to meet the needs of infants with major deformities or disabilities of a nature which would preclude mothers caring for them at home with assistance. The nursery was established to provide a facility for those youngsters who at birth were apparently doomed to a minimal opportunity for further growth and development.

Trained personnel on the staff of Field Services for the Mentally Retarded, Division of Mental Retardation, Department of Institutions and Agencies, can assist in counselling parents of retarded infants. More and more of the community clinics under the Community Mental Health Services Program are providing diagnostic and counselling services to parents and practitioners in the community who have to make serious decisions in these difficult cases. The Division of Mental Health and Hospitals also has available an additional resource: anyone in our State may call the New Jersey Mental Health Center at 441 Bellevue Avenue, Trenton, for consultation about mental, emotional, retardation or other medical problems in children if they are not able to find appropriate resources elsewhere.

The physician is most often the first one to advise family and friends about the management of handicapped children. When it is apparent that the handicapped infant must be removed from the home because of shortcoming in the home rather than because of the degree of handicap, the State Board of Child Welfare should be considered as a resource for assistance in finding a specialized foster home placement for the youngster.

P.O. Box 1237, Trenton

Liver . . . Folic Acid . . . B_{12}

When I came into medicine, one condition we called 100 per cent fatal was pernicious anemia. I remember the time when Whipple, Minot, Murphy, Castle, and Cohn discovered the use of liver for pernicious anemia. At that time, Mrs. Lilly, widow of the original Eli Lilly, was dying of pernicious anemia and had been given just a few weeks to live. She was among the first to receive great amounts of raw liver in the treatment of the fatal condition. Through the contributions of our great pharmaceutical industry, we did not just go on treating patients with raw liver. We eventually developed liver extracts of great purity, we developed stomach wall extracts, we developed also, folic acid, and still later vitamin B_{12}.—

Morris Fishbein, M.D., at New Jersey Pharmaceutical Industry Day, Union, N. J., Oct. 25, 1962.

Theodore R. Robie, M.D.

East Orange

Anti-Depressant Drug Combinations

By a judicious combination of pharmacologic and psychologic therapies, Dr. Robie reports faster and safer recoveries from depression plus the advantage of a treatment program less costly to the patient than conventional psychotherapy.

Since 1957, an amine oxidase inhibitor revolution has ushered in a new era in the treatment of emotional disturbances. Before 1957, electroconvulsive therapy had become recognized as specific treatment for suicidal melancholia by all eclectic psychiatrists. Both the thymoleptics and the MAOI's* have been remarkable in making suicidally depressed people want to stay on this planet and enjoy life again. But these new drugs opened the gates to better ways of reorienting disconsolate human beings, notably through the enhancement of psychotherapy. After all, psychotherapy is impossible while a patient is acutely melancholic. Other drugs (that were available to us before the discovery of the anti-depressant specifics) can supplement, refine or accentuate the new ones. Specific anti-depressant chemotherapy should be initiated in large dosage at once in *all* cases of melancholia, unless an actual suicidal attempt dictates electro-shock therapy immediately.

For acute pain, doctors administer an anodyne immediately. This makes existence bearable until the lesion can be mended by surgery or other measures. When a mentally sick person comes to the psychiatrist's office suffering with malignant melancholia, the doctor faces a similar emergency. He must abate this acute depressive state in some degree immediately or face the possibility of suicide as treatment begins. No anti-depressant drug can induce remission immediately. Occasional cases can be brought to remission in seven to ten days by chemical means; most patients require three to four weeks. Thus, stop-gap euphoriant therapy can often be temporarily life saving.

A simple non-narcotic chemical means of accomplishing this is to give 10 to 15 milligrams of methylphenidate (Ritalin®) parenterally. In my experience, the patient will often say, "I feel like a new man," within 20 minutes after injection, even though he had been disconsolate and sobbing before. The injection may be effective for four hours or more. It can be repeated a second time around noon each day. Do not give it in late afternoon, since it may increase the insomnia that accompanies melancholia. After a few days of this intensive methylphenidate therapy (while the amine oxidase inhibitor or thymoleptic is building up its accumulation) it will be possible to sustain a fair degree of artificial euphoria by oral administration of 40 to 60 milligrams of methylphenidate daily. This is gradually reduced to 30 or 20 milligrams a day (in divided doses) as the depression recedes through the effects of the other chemicals.

One of my patients recently received an injection of combined methylphenidate and iproniazid the first time seen, when deeply melancholic. She then routinely pleaded for "that wonderful injection" each time she re-

*Mono-amine-oxidase inhibitors.

Read at the annual meeting of the American Association of Medical Psychiatrists in Toronto, Canada on May 6, 1962.

turned for a check-up, "because it always gives me a big lift."

Sometimes excessive claims are made for a new drug. Unfortunately, assertions that chlordiazepoxide (Librium®) was a good anti-depressant chemical, crept into the manufacturer's brochures. As a result, some general practitioners expected it to function in the same way as MAOI.* A teacher developed her third manic depressive breakdown (severe melancholia) in eight years. Her family doctor prescribed chlordiazepoxide alone, which she continued for four months while her depression became steadily worse. When I added MAOI* while continuing chlordiazepoxide, a remission was induced in four weeks.

I have administered Librium® frequently in conjunction with specific anti-depressant chemicals. Chlordiazepoxide is one of the best drugs we have for attenuating the severe anxiety which is often a major element in melancholia. It may attenuate the severe apprehensiveness of involution melancholia sufficiently, to enable isocarboxazid, nialamide or phenelzine to induce remission in this most extreme agitated type of melancholia.

MALNUTRITION

PETITENESS is a fashion to which many young ladies adhere with fetishlike tenaciousness. It is not surprising to see depressed women in the second or third decade, who are 20 to 30 pounds underweight; some (who appear like cadavers) are 40 pounds underweight. My 37 years of psychiatric practice have convinced me that our first responsibility to these fashionably misguided women is to induce them (through all the chemical and dietary forces at our command) to gain weight rapidly, while prescribing anti-depressant chemicals for good measure. These almost invisible ladies are all so fatigued that some will openly blurt out, "I'm too tired to live." Others, less given to frankness, keep their suicidal intent from the ears of all, including their physicians.

One of these featherweights was a 29-year old mother of three children. She had weighed 125 pounds at the age of 17, but had dropped to 87 pounds over a 12-year period. It was possible to induce a gain of 17 pounds in five weeks, while hospitalized. The backbone of her treatment was daily insulin subshock, hypervitamin therapy and high caloric diet. To this regime, norethandrolone (Nilevar®) was added, 10 milligrams orally every 12 hours and 25 milligrams intramuscularly every second day. She continued to gain on a reduced regime after leaving the hospital. I had planned to add anti-depressant chemotherapy after a week or 10 days on the original regime, but weight gain was so marked (four pounds in ten days) and all-around improvement so evident, that I withheld them because she had a history of severe allergies and I did not wish to chance a rash, which could have delayed improvement. She never required over 52 units of insulin to induce tremendous appetite each morning. She has slowly gained a few more pounds during the past six months on intensive vitamins prescribed by her family doctor.

Another malnourished woman was a 21-year old college senior with a high scholastic rating, married six months. She tried suicide by chlorpromazine overdosage. This had been prescribed by her physician when she complained of severe tension, constipation (spastic as shown by x-ray), nausea and regurgitation. She failed to tell him the more malignant complaint of severe melancholy episodes for over two months. When the phenothiazine worsened the depression, she gulped down those remaining in the second prescription bottle, then phoned her husband and told him. What she didn't know was that some psychiatrists have *prescribed* chlorpromazine dosages as high as 2500 or 3000 milligrams per day. Her self-ingested dose of 500 milligrams merely induced partial coma for 24 hours and lethargy for another 24.

Brought to me 53 hours after taking the overdose, she described herself as: "Very, very depressed; *terrible* physically. I was sick and nauseous, *down* in the stomach, as though I had no goals in life, extremely *down* mentally. *What* was I living for?" It was found that at age 16, she had been overweight (130 pounds) and so had dieted under medical guidance. After she had reached the goal of 110 pounds, her weight kept going down. She had taken an overdosage of thyroid at camp one summer, dropping from 118 to 87 pounds.

When I first saw her, she weighed 97 pounds. She was 64 inches tall. This made her 28 pounds underweight. There was generalized pellagrous desquamation and mottling of the legs. She was started on a regime of combined anti-depressant, appetite stimulating and hypervitamin therapy and she gained 10 pounds in the first month. Although she felt a little better after a few days, it took more than two weeks before the melancholia began to recede. Accordingly, supportive psychotherapy was imperative. She received isocarboxazid and methylphenidate, norethandrolone (orally and parenterally), intensive (Spansule®) vitamins with added nicotinamide (700 milligrams daily) and 10 to 12 units of insulin daily before breakfast. Her aversion to milk precluded liquid diet foods

(Metrecal®, Nutrament®) following meals, which are usually added to this regime.

Thus, a reasonably good remission had been induced and a young woman has been saved from the discomfiture to patient or family that may occur when a depressed person gets electroshock therapy. She has also been saved, through psycho-chemotherapy, from the sometimes stigmatizing effect of psychiatric hospitalization.

A 52-year old insurance worker, who was treated for severe melancholia 10 years ago, has been followed since then because of lifelong hypertension. He was getting hydralazine (Apresoline®), but this only lowered pressure a few points. The addition of reserpine helped, but in 1959, hydrochlorothiazide (Hydro-Diuril®) brought his blood pressure down 30 millimeters and kept it there. More recently the synthesis of Pargyline® brought further improvement, and now his blood pressure is easily held in a range of 120 to 138 on combined hydrochlorothiazide and Pargyline®. Ten years has certainly produced a complete revolution in the treatment of hypertension.

A married woman of 30 had a profound melancholia plus a psychosomatic colitis which had resulted in weight loss to a point where she was 20 pounds underweight. This resulted from a severe anxiety reaction. Since chlorpromazine had been prescribed for her anxiety several weeks before, it is quite probable that her depression had been augmented by this drug, which can initiate a melancholy state just as reserpine can.

I stopped the chlorpromazine and placed her on phenelzine plus pyridoxine-iproniazid[1] as potentiator, and replaced her secobarbital (Seconal®) hypnotic with methyprylon. Diphenoxylate (Lomotil®) was given three times a day for colitis. Within two weeks, she gained five pounds, but then her blood pressure receded to 96/50 when standing. The phenelzine and iproniazid doses were reduced one-half and ephedrine then was ordered three times a day. Then her blood pressure dropped faster and she had a black-out on arising. I started corticotropin-gel (ACTH®) immediately every 12 hours. In three days, her blood pressure stabilized at 120/100. Following this difficulty, her progress continued steadily upward. She has remained in good spirits and has regained 18 pounds, through the continuation of small maintenance doses of isocarboxazid, plus norethandrolone orally and parenterally.

The tranquilizers are helpful for reducing agitation and may succeed in minimizing or (in occasional cases) subjugating delusions or even hallucinations. However, these drugs occasionally replace the original illness with a suicidal melancholia. A manic reaction may be induced when too large doses or too prolonged administration of energizer medication has occurred. In either case, the newly substituted illness must be treated. Since the altered psychiatric illness has been initiated by drug administration, it is probable that the doctor will again resort to drug therapy to induce remission of the metamorphosed illness.

With many thousands of drugs and vitamins available, some important ingredient may be left out of our therapeutic plan for a particular patient. Here is an example.

A depressed 30-year old man was ten pounds underweight. His cranky irritability had almost estranged his attractive wife. He improved slightly on an M.A.O.I.* energizer during a two-month period. When norethandrolone, parenterally and orally, was added, he gained nine pounds in five weeks and began to show new "zip." When testosterone was added to his parenteral norethandrolone, and B complex to his diet, there was even greater evidence of return of *joie de vivre*. It then seemed as though the psychotherapy that had been carried out hopefully from the beginning, was starting to bear fruit. Without the physiologic treatment in conjunction with the psychotherapy, the very worthwhile reuniting in "togetherness" of two temporarily unhappy people, could not have occurred. Improved psycho-sexual adjustment always results in better cementing any marital relationship.

An excellent remission of involution melancholia occurred in a 65-year old man. This was induced by isocarboxazid-iproniazid anti-depressant therapy in conjunction with chlordiazepoxide in 25 milligram doses three times a day, later reduced to ten milligrams twice a day. Although maintained on a gradually reducing isocarboxazid dosage for ten months following this breakdown, he never had an elevated transaminase (13 performed!).

He did well during the next eight months with no chemotherapy or psychotherapy. Then he experienced a recurrence of agitated depression, which developed while I was in Switzerland.. The doctor who substituted during my absence initiated treatment with small doses of amitriptyline (Elavil®), increased to moderate doses after a week. When I returned three weeks later, he was still depressed and continued so, in spite of further increase in amitriptyline dosage. He suffered recurrence of hyper-anxiety provoking obsessive thoughts in his depressions. When I tried potentiating the amitriptyline by intravenous injection of the same chemical, I encountered my first (and let me assure you, a most frightening) allergic reaction in this man, following an intravenous in-

1. Iproniazid is recognized by chemotherapists as probably the best anti-depressant chemical so far discovered, but prolonged large dosage may cause complications. However, in small dosage and with frequent transaminase check-ups, it is irreplaceable in these very precarious stages of acute melancholia.

jection of only 12 milligrams. This is a very small dose compared to the 30 milligram doses I have given many patients and larger doses given by others. Ashen cyanosis was extreme with generalized diaphoresis and blood pressures as low as 80/60; and even 0/0. His repeated proclamations of impending death left nothing more to be desired in the way of sensational experience for me on that day. However, after three hours he gradually improved. Caffeine injections had sustained him through the worst moments and with sizeable amounts of Corticotropin-Gel® helped sustain him after departure. I had seen this highly suggestible man in faints before when blood samples were drawn, but never in such prolonged, apparently terminal, syncope.

After this harrowing experience, depression worsened following a two-day interval with no amitriptyline. He was again placed on isocarboxazid, which had induced remission 1½ years before. In ten days, he was improved; but four days after that, there was a return of acute anxiety. I then tried diazepan (Valium®), which is a potent and very hypotensive new tranquilizer. This did a remarkable job of calming his hyper-anxiety, but soon cortisone was necessary for the hypotension it caused. Then, after limping along three more weeks on diazepan, isocarboxazid and cortisone, plus extra methylphenidate if needed, he began to show real improvement. Thus, again isocarboxazid takes credit for remission, but two months were lost in attempting remission through amitriptyline.

Amitriptyline doesn't do too well with the extreme depression. These patients do best on amine oxidase inhibitors.

Since we cannot anticipate who may be allergic to intravenous amitriptyline, it is advisable not to give more than six milligrams the first time. In only one patient did I run into any real allergy to intravenous amitriptyline. In fact, I have observed substantial enhancement of the effectiveness of amitriptyline by giving 12 to 16 milligrams intravenously each day (combined with equal volumes of sterile water to prevent ecchymoses at the injection site), while the oral dosage is continued. This intravenous therapy is particularly helpful for severe anxiety hysteria. In one of these, the patient demands the injection each time she comes for psychotherapy, insisting it helps her "ventilate" her thoughts more spontaneously. Apparently it does improve rapport. There is always an initial lowering of blood pressure both prone and standing, but it returns to its previous level in 20 to 30 minutes.

Dextro-amphetamine sulfate has long been administered to potentiate the effectiveness of amine oxidase inhibitor therapy. Daily doses of five or ten milligrams will often accomplish this. Recently, an able researcher demonstrated that d-amphetamine given conjointly, potentiates the anti-depressant effects of imipramine. I applied the same principle with amitriptyline and obtained the same result: augmentation of the anti-depressant effect. However, it is important when anyone administers these two drugs together, to anticipate accentuation of the tranquilizing effect in those persons who experience tranquilization when first given amitriptyline. Here is an example:

A depressed 14-year old girl, when given five milligrams of dextro-amphetamine with 25 milligrams of amitriptyline for her first dose in the morning, went to sleep for several hours. She was lethargic for the rest of the day. Thus, the combined chemicals could be given at bedtime advantageously in this kind of patient—at least early in the treatment.

Because of this experience, I now start patients on 2.5 milligrams of dextro-amphetamine with 12 milligrams of amitriptyline or less. The lethargic effect of amitriptyline recedes after a few days of treatment.

Stein has shown that d-amphetamine augments the effects of chlorpromazine, and that when both imipramine and chlorpromazine are given to the same patient and then d-amphetamine is added, the greater augmentation of chlorpromazine blocks out the imipramine effect. Obviously then, one should not try to potentiate amitriptyline by d-amphetamine, if the patient is given chlorpromazine at the same time, since the anti-depressant effect would be neutralized and the depression would persist.

In some patients who get amitriptyline (particularly those who complain of insomnia) it may prove advantageous to give the major part of the dosage at night. In this way, the tranquilizing effect is put to work inducing sleep, thus avoiding the addition of a specific hypnotic for this purpose. A 25 milligram tablet at eight or nine p.m. and another on going to bed, may be salutary. In one of my patients who formerly required heavy specific nocturnal sedation, a 10 milligram amitriptyline now provides eight hours of good sleep,

plus anti-depressant chemotherapeutic effect.

In contrast to this patient where allergy was encountered from amitriptyline, many good results have been observed. Here is an example:

A 50-year old matron consulted doctors for many years because of various phobias. Ultimately, she gravitated to my office with a reactive depression.

She was first started on a moderate dose of an assumedly safe amine oxidase inhibitor. It turned out that she was one of the few who develop marked hypotension from amine oxidase inhibitor medication. She suffered a near black-out after only 13 days on this chemical. Her blood pressure had dropped 80 millimeters from the original reading! Cortisone and Corticotropin-Gel® overcame this dramatic hypotensive effect and it was possible to resume the amine oxidase inhibitor in considerably reduced dosage. Six weeks later, on moderate maintenance dosage without cortisone, recurrence of hypotensive reaction made it obviously necessary to stop amine oxidase inhibitor medication.

After a four-day interval (to assure dissipation of most of the accumulated amine oxidase inhibitor) amitriptyline was initiated. There was noticeable improvement within a few days and no hypotension occurred. The improvement continued, but she had to watch her diet to prevent weight gain even on small dosage.

It appears that we had found a successful aid to the psychotherapeutic and chlorpromazine calming effect upon this woman's phobias, since they have been quiescent or minimal for several months now. Even more noteworthy is the maintenance of a blood pressure plateau 40 millimeters below the original high of 180, with no disturbing hypotensive effect at any time over a five-month period of reasonably good readjustment. Amitriptyline did cause some degree of day-time lethargy, even on her small dosage. It is reasonable to assume that the constructive physiologic change of a considerable reduction in blood pressure (from a pathologically high level to a chemically induced normal level for her age) is a major factor.

I stress the need for sitting and standing blood pressure recorded at frequent intervals on all patients who are taking any amine oxidase inhibitor. There could have been no more dramatic proof of this than the following experience.

A physician who recovered from previous episodes of melancholia on amine oxidase inhibitor therapy had a recurrence of depression just before etryptamine was taken of the market. He had stocked a small supply of tablets, but on learning that etryptamine was withdrawn, he discontinued taking it. Soon thereafter, his dispression became more aggravated and (again on his own initiative) he undertook treatment with tranylcypromine (Parnate®). He started with the dose recommended on all the printed filers supplied with each package: 10 milligrams twice daily. After a week, he became anxious about it and telephoned me, asking advice. I advised that when taking tranylcypromine, he keep careful daily records of his *sitting and standing blood pressure,* and that ephedrine or cortisone would become necessary if hypotension should occur.

Only 24 hours later, he phoned me in considerable anxiety. He discovered that his blood pressure (formerly at 140, sitting) had dropped to 90/70 sitting and 80/60 standing. He had become very dizzy on the eighth day of treatment. I had emphasized this possibility to him on the previous day. This has been my experience on frequent occasions with tranylcypromine.

He was advised to administer Corticotropin-Gel® immediately and twice daily if necessary and also to take cortisone orally, 25 milligrams two or three times daily in addition. He was warned not to ambulate so long as his blood pressure remained this low. I advised him not to resume his practice until his *standing pressure* reached 96 or higher.

When pargyline hydrochloride‡ first came on the scene in October 1961, the suggested doses were higher than subsequent research found to be necessary. It is possible, however, that these larger doses (50 milligrams two or three times daily) may be essential to produce the anti-depressant effects hoped for when pargyline is administered. Yet, such large doses will cause very severe and rapidly induced hypotension. Serious accidents could occur to patients who are given these large doses if they are not frequently observed. By "frequently," I certainly mean *daily* observation. Even when given smaller doses, these patients need to be seen a minimum of twice weekly.

Recently, a patient placed on my present maximum starting dosage of pargyline, 25 milligrams every 12 hours, showed a reduction in blood pressure from 180/104 (sitting) down to 130/96 (50 millimeters lower!) in two weeks.

After a week on this medication, there had occurred only slight reduction: an 8 millimeter fall in the *sitting* blood pressure.

This patient showed further reduction in blood pressure a full month after the pargyline had been started (from 180/108 to 106/60 *sitting;* from 168/96 down to 70/48 *standing*). Although the standing blood pressure dropped almost 100 millimeters, there were no complaints of dizziness or

‡ MO911 Abbott—later named "Eutonyl."

faintness and no ataxia or balance control variances were apparent.

This case seems to suggest (as have some others) that there is more safety in the inherent hypotensive effects that may accrue from pargyline, than in the comparable effects with B-phenylisopropyl hydrazine, iproniazid and tranylcypromine. All these have hypotensive propensities. However, it would be foolhardy to suggest that this factor would warrant large doses of pargyline and then forgetting the patient. Still, it does give a greater sense of security to realize that the patient can apparently withstand lower blood pressure when taking this new MAOI,* pargyline.

Unfortunately, however, pargyline is not as consistently anti-depressant in its effects as all three others mentioned above. However, it is adequate to maintatin many on a plateau of eudaemonia† with no supplementary aid from other anti-depressants.

A 64-year old widow had had recurrent depressive episodes since her son was killed during the war. Electroshock therapy had been used for four previous breakdowns. When I first saw her, I gave etryptamine combined with pargyline because of marked hypertension. In two weeks, she showed a degree of improvement. Her blood pressure had been lowered by 40 millimeters. Although etryptamine had to be withdrawn after six weeks, she has continued in excellent remission and her blood pressure is maintained at 140 (instead of the original 180) on minimal pargyline dosage. All transaminase tests have been normal (8 to 16) as have her white blood cell counts.

A 40-year old man came to me in a severe depression. He had been under psychoanalysis for several weeks, but the analyst decided more definitive treatment for his melancholia was imperative. The analyst said that he must be given electroshock therapy, or he'd have no patient.

I suggested anti-depressant chemotherapy. The patient was skeptical, since his analyst had said he must have shock. I insisted on chemotherapy. In three weeks, a good remission was evident. By the fourth week, he was pleased that he had been saved the cost and other difficulties that might have been encountered if electric shock had been given. And now that he is no longer depressed, he sees no reason for resuming analysis. I see him every three weeks. He is doing well on a maintenance dose of five milligrams of isocarboxazid daily after having passed through intensive treatment with isocarboxazid 40 milligrams daily in the beginning, gradually reduced to 10 milligrams and now down to five. He did receive adjunctive methylphenidate and iproniazid injections bi-weekly for his first three visits. All transaminase tests have been normal and good remission has been maintained for eight months.

Another good result is that of a 64-year old woman who became very depressed following her husband's death. After successful intensive therapy with certain anti-depressants which induced serious side effects (hypotension), she did very well on etryptamine for 1½ years. When deprived of this she promptly relapsed into melancholia. By manipulating pargyline dosage, I was able to induce a good remission from the etryptamine deprivation depression. Although she has been a serious problem in hypertension and has only one kidney, she is now maintained in good remission on only 15 milligrams of pargyline daily.

Blood pressure usually remains 10 to 20 millimeters below her usually hypertensive level on this dose of pargyline, but occasional increase to 20 or 25 milligrams daily is necessary.

PSYCHOTHERAPY

PSYCHOTHERAPY is a major part of every contact between psychiatrist and patient. The aim of all chemotherapy or physiologic (shock) therapy in psychiatric illness is the enhancement of psychotherapy. No person, no school, no psychiatrist, has a "patent" on any type of psychotherapy. Every psychiatrist will have inculcated, during his years of training, a recognition of the basic Freudian principles. Most psychiatrists today apply psychoanalytically-oriented viewpoints in our everyday conferences with patients.

It is my policy (and I believe that of many contemporaries) to concentrate on the chemical or physiologic means of attenuating the presenting symptom of tension, anxiety, agitation, depression (even stupor) or combinations of these during the one to four weeks that may be necessary to enhance the patient's capacity for cooperation in psychotherapy. Thereafter, as the patient's optimism continues through chemical aids, we can concentrate on psychotherapy while the persisting need for physical examinations and laboratory reviews are continued on a weekly or bi-monthly basis.

†Your editor can't find *eudaemonia* in his medical dictionary either. However, a little research into Greek indicates that a demon (*daimon*) was originally any kind of spirit or divinity; and *eu*, of course, means good (as in eulogy or euphemism), so presumably "eudaemonia" must mean "good spirits." The difference between *eudaemonia* and *euphoria* might be a good subject for a Ph.D. thesis.

The term "eudaemonia" was first used by Dr. Elmer Sevringhaus.—T.R.R.

It is rare that an eclectic psychiatrist observes a patient less than three months; it is usually over a period of one or two years and sometimes longer.

The question often arises as to how these regulators disseminate greater quantities of serotonin and/or norepinephrine throughout the central nervous system, and how this chemico-physiologic activity fits in with our (until recently) accepted psychosomatic theories? My concept is this:

Psychoanalysis can mitigate—perhaps it can even obliterate certain physical symptoms such as chronic fatigue or neurotic depression. This is subject to these provisos: (a) that the symptoms resulted from long and unmitigated mental conflict; (b) that the patient's finance and patience can await the one, two or three years that analytic therapy may require; and (c) that suicide does not put an end to this valuable therapeutic process. It is, therefore, good that we can now shorten the psychotherapeutic process by neutralizing certain symptoms through chemotherapy. This is particularly true of the major presenting symptoms of retarded mentation and melancholia. The individual can thereby be converted much more quickly into an efficiently functioning human machine, reassuming his vocational duties as "he feels *good* once more."

By means of the MAOI* regulating mechanism, the serotonin and norepinephrine which have been "bound" in the blood platelets and elsewhere (performing no useful function) can be called to duty to put the temporarily incapacitated human machine back into a functioning status. Once back on the job earning a living, with a return of spontaneity, psychotherapeutic effort (psychoanalytic or other) can more efficiently be conducted, and resolution of the psychic conflicts which originally caused the breakdown of duty performance by the all-important catecholamines (serotonin and norepinephrine) may be accomplished.

This approach, actually a complete reversal of the original Freudian procedure, should prove a boon to dynamically oriented psychiatrists since the chemical therapy does enhance rapport. The patient's increased spontaneity assures more efficient progress of the analytic process than the previous slow sessions that occurred when retarded mentation allowed almost no elaboration by the patient of his inner problems. Thus, the ultimate major advantage of MAOI* therapy may not primarily be its beneficial remission of melancholia, but rather its use to promote optimal conditions for psychotherapeutic treatment.

In the earliest papers on the use of amine oxidase inhibitors, the authors appeared to assume that there would be a stage when energizer therapy could be discontinued after graduating the quantity down to a sixth, a tenth, even one-fifteenth of the starting dose. We have now been using these chemicals for five years, and that is long enough to justify this conclusion based on my experience. Just as there are many who will require intensive vitamin therapy the remainder of their lives (once a diagnosis has been established) just so will there be a need for energizer therapy in minimal dosage for the remainder of the lives of a large proportion of those who have found it a happiness inducer and maintainer.

This fact will play a major role in the psychiatry of tomorrow. It is utterly impossible to train sufficient psychiatrists to meet today's needs in terms of the high frequency of long visits required by adherence to analytic psychotherapeutic principles. Now, however, a powerful chemical can take over a very considerable portion of the work that psychotherapy alone has tried to accomplish through the transference phenomenon in the past 60 years. It does this by inducing eudaemonia† in formerly chronic melancholic individuals. This makes possible a tremendous reduction in the frequency of visits to the psychiatrist. This means that each psychiatrist can treat a considerably larger number of patients than was possible in the past. In my own practice, concomitant with the precipitate reduction in the number of patients requiring electric shock, simultaneously it has been possible to assume a larger case load through a more scientific control of chemical dosage by the Wroblewski transaminase test. At the same time, this assures greater safety to the patient receiving this extraordinarily valuable, yet precarious chemical therapy. A rough numerical comparison of similar months of my practice

during 1955 (before energizer therapy) and 1959 (after transaminase controlled energizer therapy) shows at least a 35 per cent increase in the number of patients seen; yet a satisfactory plan of psychotherapy was maintained.

It is possible after the first month of intensive combined psycho-pharmacologic therapy with any new depressed patient to reduce the frequency of office visits from every five or seven days to once in ten or 12 days; and by the third month, the frequency can be further reduced to once every two or three weeks. This places psychiatric treatment within economic reach of a vastly increased number of individuals and makes it no longer a luxury available only to the rich.

676 Park Avenue

COMBINED CHEMICALS FOR MELANCHOLIA

A recently discovered chemical gives great promise of a far better means of preventing hypotension, or of quickly reducing this, when it occurs during the administration of monoamine oxidase inhibitors. This side effect of these remarkable anti-depressant chemicals has prevented some doctors prescribing them in many instances where they could have been invaluable. This is one more example of the rapidity with which bio-chemical knowledge has progressed in the short span of six years in the treatment of melancholia, which encompasses a major portion of functional mental illness.

It is well known to all at this time, that the tranquilizers advanced mightily the treatment of the great mass of psychiatric illness to a point where, for the first time in modern history, the tremendous population in our mental hospitals began to show reduction in number during the last few years.

Although the following list does not cover all of the pharmaceutical companies that have played key roles in discovering and promoting the use of bio-chemicals now known to be indispensable for the treatment of mental illness, it does cover the list of pharmaceutical companies whose products have been found useful in the psychochemotherapeutic measures instituted in the treatment of depressed patients delineated in this paper.

Abbott Laboratories
Armour Pharmaceutical Co.
Ayerst Laboratories
Burroughs-Wellcome Co.
Ciba Pharmaceutical Co.
Geigy Pharmaceuticals
Hoffmann-LaRoche, Inc.
Lakeside Laboratories
Lederle Laboratories
Eli Lilly and Co.
Mead Johnson Laboratories
Merck Sharp & Dohme
Pfizer Laboratories
Pitman-Moore Co.
Premo Pharmaceutical Labs., Inc.
Sandoz Pharmaceuticals
Schering Corp.
G. D. Searle and Co.
Smith, Kline & French Labs.
E. R. Squibb & Sons
U. S. Vitamin & Pharmaceutical Corp.
Upjohn Co.
Wallace Laboratories
Warner-Chilcott Laboratories
White Laboratories
Wyeth Laboratories

Heart Disease and Flying Booklet for the Public

The decision to remove Major Slayton as pilot of this country's second orbital space flight because of a heart condition has increased the concern of many heart patients over their own welfare in the air. The rule of thumb followed today, said Dr. George J. Kodera, a Chicago specialist in aviation medicine, is "if you can walk a city block or climb a flight of stairs, you can travel in today's commercial airliners."

—*Modern Medicine*, April 2, 1962.

Seymour L. Hanfling, M.D.

William B. Nevius, M.D.

East Orange

Stevens-Johnson Disease in Infants

Report of Two Cases in One Hospital Within Two Weeks

Stevens-Johnson disease is occasionally fatal, but—in the two cases here reported—responded swiftly to vigorous treatment.

In 1922 Stevens and Johnson[1] described a form of erythema multiforme bullosum characterized by involvement of mucous membranes and by fever, conjunctivitis and constitutional symptoms. It is not a common disorder, and what makes these two cases unusual is that they were hospitalized on the same pediatric service within two weeks of each other. Also interesting, and worth reporting is the fact that clinical course of the two babies and their successful treatment methods were almost identical.

CASE ONE

A 13-month old girl was admitted to the East Orange General Hospital because of anorexia, irritability, a rash over the upper part of the trunk, and a tendency for the skin to desquamate. Two days previously she had a slight flush of the shoulder area which faded after a few hours. The rash reappeared the morning of the day prior to admission; the same area of the body was involved and the child appeared irritable when the mother lifted her. The family doctor gave her penicillin. Overnight, the rash became more pronounced, and the baby became increasingly irritable. The skin began to desquamate easily in small isolated patches. Two months earlier, the infant had been in the same hospital with tonsillitis. She then received considerable penicillin. She also had had a penicillin injection previously for an upper respiratory infection and again shortly after leaving the hospital. Four weeks before this admission, she was given one Salk injection (containing penicillin?) and was vaccinated. Two days before hospitalization she ate some Polish sausage (kielbasa). The parents were well and there was no history of allergy. A five-year old brother was in good health.

She was a well-developed and well-nourished infant with a reddish, slightly indurated rash over the upper trunk and shoulders and a suggestive vesicular appearance around the nares. No wheals or pustules were present. Where the skin had been slightly traumatised (as by lifting her under the armpits), it desquamated easily. Several areas the size of an adult's finger tip peeled off in the scapular areas as well as one over the right temple and right eye (positive Nikolsky's sign). Rectal temperature was 100. Pulse was 124. The tonsils were small, moderately red, and showed a few patches of white exudate. It did not suggest scarlet fever nor did the tongue appear strawberry-like. The rest of the physical examination was essentially negative.

The admission blood count showed 10.4 Grams of hemoglobin. Leucocyte count was 12,900 with a differential of polymorphonuclears 50 per cent; juveniles 4 per cent; lymphocytes 42 per cent; and monocytes 4 per cent. Hematocrit was 38 per cent, and total eosinophiles 11 cubic millimeters. Urinalysis revealed: acetone 4 plus, sugar, albumin and microscopic negative. The dermatologist confirmed the admission diagnosis of possible Stevens-Johnson disease and vigorous treatment was begun.

We started with a proprietary corticosteroid, a beta methasone trade-named Celestone® (Schering) 0.6 milligrams four times a day. We applied Neocordran® ointment to all affected areas, also four times a day. The regime included oxytetracycline (in the Pfizer brand, trade-named Terramycin®) 50 milligrams intramuscularly every eight hours, plus Pfizer's Terramycin® Pediatric drops—30 drops to start with and 20 drops every four hours. We used the Organon brand of ACTH trade-named Cortrophin® zinc 20 units intramuscularly *stat* and then every other day. The child received a tea-

spoonful of a proprietary elixir of diphenhydramine (we used the Parke Davis brand trade-named Elixir of Benadryl®) and then gave a half teaspoonful of the elixir every four hours. The program included a high vitamin diet plus the Mead Johnson vitamin mixture trade-named Poly-Vi-Sol® 0.6 cubic centimeter every eight hours. On this regime, she improved swiftly and on the third day after admission, she was more active and less irritable. At this time, it was apparent that the skin lesions were healing.

Now her appetite and fluid intake were good and her temperature normal. By the third day the Celestone was reduced to 0.6 milligrams twice a day and by the fifth day, to only twice a day. Gradual reduction of the oxytetracycline began on the 8th day. It was discontinued on the 12th day. Syrup of Potassium 0.3 Grams was added on the 8th day and diphenhydramine was discontinued on the 10th day. The ACTH zinc was continued until her discharge on the 16th day. At this time her skin was clear, her temperature normal, and her appetite and spirits good. There has been no relapse during the eight months of subsequent observation.

CASE TWO

On the day the above-described patient was discharged, there was admitted to the same hospital a four-month old girl who suffered from a generalized eruption, marked irritability and loss of appetite. Whenever this baby was picked up she seemed to be in considerable discomfort. The skin lesion had started four days prior to admission. First the chin, later the ears, became red. By the next night, the entire face was erythematous. The family physician recommended an enema, milk of magnesia, and paregoric. On the next day, he saw the child who then had the erythema on her body also. He gave an injection of penicillin plus oral steroids. Twenty-four hours later, the entire body was erythematous and was desquamating in large sheets over the torso and extremities.

The past history was negative. The baby had been delivered by cesarian section. There was no history of allergies, illnesses, or drug ingestion. The parents were well with no pertinent history of allergies or illnesses. The patient had a two-year old brother whose past history was also negative.

She was a somewhat fat female child covered by a dusky, erythematous eruption which, in some areas, showed groups of small vesicles, most of which were secondarily infected. There were large sheets of desquamated skin over the lateral aspect of both thighs and torso. The conjunctivae were markedly injected, and the discharge from the eyes was crusted on the eye-lids. There was desquamation of areas of the mucous membrane of the mouth, lips, and tongue. Similar involvement was present on the vaginal lips with some crusting. The pediatric consultant who examined the child found no other physical changes.

Hemoglobin was 10.6 Grams on admission but within a week it was 12.9. White cell count was 7900 with a normal differential spectrum. Hematocrit rose from 32 to 40 per cent during the first weeks of hospitalization.

Treatment began immediately on admission. We used beta methasone (Schering's brand trade-named Celestone®) 0.3 milligrams four times a day plus a Lederle brand of tetracycline trade-named Achromycin®. This was given in the form of the suspension 63 milligrams four times a day. We also applied an Upjohn hydrocortisone-neomycin combination trade-named Neocortef® in the form of an ophthalmic cream, four times a day. Our regime included a bacitracin-neomycin ointment to the body four times a day, and 10 units of an ACTH gel every second day. The diet prescribed was the usual one for a four-month old infant. We gave 15 milligrams of phenobarbital in elixir form each night plus baths of a colloidal oatmeal preparation (Aveeno®) twice a week.

Although she ate poorly on admission (probably due to her sore mouth and general discomfort) she responded rapidly to treatment. Within 48 hours, the swelling of her face had subsided, she was eating well, and the skin was less inflamed. Clearing was rapid with no complications until the tenth day of hospitalization, when the practically healed skin became denuded in the flexures and folds of the neck, and showed some tiny satellite lesions. This was treated as a moniliasis with nystatin, USP (we used the Squibb brand trade-named Mycostatin®) in cream and powder form. The skin responded to this within 48 hours.

The dosage of Celestone® was gradually decreased. The ophthalmic and skin ointments were discontinued after one week, and the ACTH upon discharge from the hospital on the 13th day. She was on a maintenance dose of Celestone® 0.15 milligrams twice a day which was continued at home for six weeks. Since the termination of all treatment at that time, six months follow-up showed no relapse.

In 1922, Stevens and Johnson [1] reported two cases, in boys of seven and eight years of age, of an extraordinary, generalized, eruption with continued fever, inflamed buccal mucosa, and severe purulent conjunctivitis. These children recovered after five weeks, one having a severe corneal scar and the other, loss of vision in both eyes. Subsequently, the designation Stevens-Johnson disease has been applied to certain acute fulminating illnesses with a similar symptomatology, usually with a grave prognosis, and an obscure etiology. In recent years, the prognosis has improved greatly with the use of steroid and antibiotic therapy.

Costello [2] has described in considerable detail the symptoms and clinical course of this disease. He suggested [3] the name erythema bullosum malignans-pluriorificial type, and pointed out the differential diagnoses that must

be considered. In 1947, he reported[2] on 17 cases selected from 33 at the Willard Parker Hospital in New York City, between 1932 and 1946. Of these 17 cases, 14 were male. The list included ten adults and seven children, the youngest of whom was a 14 month-old boy. Three patients of this group died.

The clinical course is characterized by a sudden onset with chills, rapidly increasing fever, and prostration somewhat resembling grippe. The orificial membranes become involved with vesicular and bullous lesions about the time that areas of edema appear on the skin. These lesions may form large bullae which rupture spontaneously in a few days, leaving red, denuded areas. The eruption tends to be most intense on the face, neck and ears, upper part of the trunk, and extensor surfaces of the extremities. The scalp is generally spared. Superficial layers of skin seem to rub off with little trauma. The skin vulnerability is known as Nikolsky's sign. One serious danger in this disease is corneal ulceration—a complication that may lead to loss of vision. Duration of Stevens-Johnson disease varies from two to four weeks, depending on severity. At the time Costello's first paper (1947) was written,[2] no specific treatment was known. Penicillin was just being made available and Costello attributes recovery in two cases to its use. Steroid therapy, of course, was not available until several years later. The specificity of this therapy is still questioned.[7]

Some authorities believe that this syndrome is an acute infectious disease and suspect a viral etiology. Other authors believe it to be the result of a drug sensitivity and the following drugs have been suspected: trimethadione, paramethadione,[4] mebroin, diphenylhydantoin, sulfonamides, penicillin, salicylates, thiouracil, phenylbutazone, codeine, Fowler's solution, phenolphthalein, and barbiturates.[5] Others consider it a non-specific hypersensitivity response to a number of environmental factors, only some of which are drugs, others being infections both bacterial and viral. Swaiman and Raile[6] state that the Stevens-Johnson syndrome has been seen following mumps, atypical pneumonia, smallpox vaccination, and psittacosis.

In his second paper,[3] published in 1953, Costello describes in much detail the various types of bullous dermatoses of which the Stevens-Johnson type of erythema multiforme (as he now calls it) is one. The conditions that most resemble it and need differentiation are pemphigus vulgaris, the bullous type of dermatitis herpetiformis, and erythema multiforme pemphigoides. From a pediatric point of view, difficulty might be experienced with severe varicella, generalized vaccinia, variola, and severe diphtheria.

Rallison *et al.*[5] report three cases of erythema multiforme exudativum (Stevens-Johnson syndrome) following administration of anti-convulsant drugs resulting in a lupus-like disease characterized by the L.E. cell phenomenon, with or without renal and systemic involvement, which was reversible on discontinuance of the drug. The simultaneous occurrence (in two of their cases) of erythema multiforme, a disease state which is probably hyperreactive in nature, lends further support to the viewpoint that both lupus erythematosus and erythema multiforme represent abnormal responses to different inciting agents, and that an abnormal immune system is operative in these patients. The mechanism by which these medicinal agents produce a disease so closely related to spontaneous lupus erythematosus has not been clarified, however. They believe that in their patients, they have observed the development of true lupus erythematosus, precipitated by an exogenous agent which may be identified. In these few patients, the exogenous factor, being identifiable, can be removed and, with or without suppresive steroid therapy, the disease can be reversed. In idiopathic lupus erythematosus, the factor responsible for producing the disease remain unrecognized, so that in spite of suppressive treatment the underlying processes remain present, and the disease either progresses in spite of treatment or flares up when treatment is discontinued.

SUMMARY

1. Two cases are presented of Stevens-Johnson disease in female infants of four months and thirteen months of age. Both ap-

peared in the Pediatric Department of a 200-bed community hospital within a two-week period. They were treated aggressively with a steroid and an antibiotic, and both recovered.

2. The etiologic factor in these cases is not known. Cases of Stevens-Johnson disease have been reported following the use of a number of relatively common drugs, such as sulfonamides, penicillin, and trimethadione, and following the occurrence of common infections, such as mumps, atypical pneumonia, and smallpox vaccination. The most attractive hypothesis as to its cause is that it represents a hypersensitivity reaction to some known or unknown factor. Vigorous steroid and antibiotic therapy appear to affect the clinical course of the disease very favorably.

The authors express their thanks to Doctor Lawrence D'Aries and Doctor Robert D'Agostini for permitting them to see and report these cases.

572 Park Avenue (Dr. Nevius)

BIBLIOGRAPHY

1. Stevens, A. M. and Johnson, F. C.: Am. J. Dis. Child., 24:526 (December) 1922.
2. Costello, M. J.: J. Invest. Dermat., 8:127 (March) 1947.
3. Costello, M. J.: New York State Jour. Med., 53:2075 (September 15) 1953.
4. Ergas, M. S.: *Helvetica Paed. Acta.* 16. Fase. 4:374 (September) 1961.
5. Raiilson, M. D., *et al.*: Am. J. Dis. Children, 101:725 (June) 1961.
6. Swaiman, K. F. and Raile, R. B.: Minnesota Medicine, 41:479 (July) 1958.
7. Mitchell, J. H.: Postgrad. Med. Jour., 34:384 (July) 1958.

The Physician's Right to New Drugs

The government should determine the safety of a drug, be sure that the facts about it—both good and bad—are known, and that the manufacturing controls are such that the product is of a uniform, predetermined quality. Then the medical profession should decide what to use and what not to use. Different drugs affect different people in various ways. No research, no matter how carefully done, or how extensive, can establish definitely all the potential idiosyncrasies of various people towards any single drug. To set up a procedure whereby a Government department must make an affirmative decision as to whether a physician has the *right* to see if some new medicine can be useful in some desperate case, seems to be going beyond the concept of a democratic government.

Joel Y. Lund, President, The Proprietary Association, at 81st Annual Meeting, White Sulphur Springs, W. Va., May 18, 1962.

Too Many Drugs Better Than Too Few

Despite the seeming inefficiencies of free competition, I would rather be deluged with more medical preparations than be forced to sit idle at the bedside of a patient—doing nothing because there are not enough drugs to save lives or comfort my patients. As the president of a pharmaceutical firm, I would rather be accused of trying too hard to market my useful products than to default on marketing and—as a result—lose sales and thereby increase the costs of products to the consumer.

—Theodore Klumpp, M.D., in *New Medical Materia*, June 1962.

E. N. Mattioli, M.D.

Charles Cunningham, M.D.

Vineland

Perforated Abdominal Aneurysm Presenting Azotemia

The diagnosis of abdominal aneurysm may be obscured until too late for successful surgical intervention. In this case a timely diagnosis made effective surgery possible.

Perforated abdominal aneurysm is now amenable to surgical intervention. However, early diagnosis in the presence of obscure clinical evidence is vital if it is to be managed successfully. This report is intended to alert the physician to the fact that a diagnosis of abdominal aneurysm may be obscured by azotemia, a non-pulsating abdominal mass and negative roentgenograms of the abdomen.

A 72-year old male was first admitted to the hospital because of bleeding duodenal ulcer. He had vague, bizarre abdominal pains associated with "heartburn," relieved by antacids. He had epigastric distress and tarry stools of one week's duration. He gave a history of "kidney disease" which had been diagnosed 15 years prior to admission, the exact nature of which could not be determined.

Physical examination disclosed no abdominal masses. Only significant finding was slight epigastric tenderness. Chest x-ray and gastrointestinal series with preliminary flat plate of the abdomen revealed arteriosclerotic cardiovascular disease—compensated, and deformed duodenal bulb, probably on the basis of acute inflammatory disease. Electrocardiogram was normal.

First laboratory work-up revealed: hemoglobin 9 Grams, hematocrit 31 per cent; Mazzini nonreactive; postprandial blood sugar 105; blood urea nitrogen 19; carbon dioxide 24 mols. per liter; chlorides 106; potassium 5.5 and sodium 143.

He received blood transfusions pre-operatively. On the ninth day, a bilateral vagectomy and gastrojejunostomy were done. Exploration at that time disclosed no evidence of abdominal aneurysm.

The patient had a stormy postoperative course with left basilar pneumonitis and segmental atelectasis of the lower third of the right lung field. He recovered and was discharged on the 29th day.

Three months later, he returned to the hospital because of vomiting of one week's duration and pain in the lower back and right hip regions. He reported a 20-pound weight loss in the past two months. He denied hematemesis or melena.

He was given 1000 cubic centimeters of glucose and water and 1000 cubic centimeters of glucose and saline intravenously. Laboratory studies done the following day revealed hemoglobin 13.5 Grams; hematocrit 44 per cent; white blood count 7,750 with 45 polynuclears, 3 bands, 35 lymphocytes, 5 mononuclears, 1 eosinophil and 1 basophil. Urinalysis was reported as yellow and clear, acid reaction, specific gravity of 1.010, trace of albumin, negative for sugar and acetone, 1 to 2 white blood cells, rare red blood cells, a few epithelial cells, a few hyaline and rare granular casts. Blood sugar was 108; blood urea nitrogen 86 milligrams; creatinine 4.2; carbon dioxide 21 mols. per liter; chlorides 94; potassium 4.3; and sodium 136. Repeat blood urea nitrogen the same day was reported at 81 milligrams per cent. The next day, an upper gastrointestinal series with a preliminary flat plate of the abdomen was done and was found to be noncontributory.

Two days later, it was noted that the size of the abdominal mass had increased. Intravenous fluids were repeated and tenderness of the mass in the right lower quadrant was noted. At urologic consultation the same day, transmitted pulsations were reported. There was also noted to be a drop in the hemoglobin from 13.5 to 11.5 and a drop in the hematocrit from 44 to 39 per cent. White blood count and differential and urinalysis were essentially normal. The next day, the blood urea

nitrogen was 41 and creatinine was 2 milligrams per cent. Barium enema was reported as normal. Three days later, cystoscopy and retrograde pyelography revealed the middle third of the ureter to be laterally placed. The possibility of enlarged peri-ureteral lymph nodes or aortic aneurysm producing this effect could not be ruled out.

Next day, there was a further drop in the hemoglobin to 10.5 Grams and in the hematocrit to 38 per cent. The pulsating mass was now described as being below the subcostal margin predominantly on the right side, extending about two inches to three inches below the umbilicus. It was approximately five inches in size and was painful and tender. It was concluded that an abdominal aortic aneurysm was present with impending perforation. The temporary elevation of the blood urea nitrogen, it was believed, could best be explained as partial obstruction of the renal vessels which was corrected by the patient's being put to bed, and the drop in the hemoglobin from 13.5 Grams to 10.5 Grams and in the hematocrit from 44 to 38 per cent (despite parenteral therapy and no vomiting) as a manifestation of occult bleeding, probably retroperitoneal. A second surgical consultation held the next day corroborated this opinion.

An intravenous aortography was done in the manner described by Steinberg, *et al.*[6] This was not satisfactory. Subsequently, a retrograde aortography was tried by means of a No. 15 polyethylene catheter, but again, results were unsatisfactory.

The patient received two pints of blood preoperatively, elevating the hemoglobin to 12 and the hematocrit to 40.5. Pre-operatively, the blood pressure was variable, averaging 150/100.

At operation, we found a walled-off perforation on the posterolateral and inferior portions of the aneurysm against the vena cava. There was also a second aneurysm of the right common iliac artery. The dissection necessitated transecting the right external iliac artery and ligating the right internal iliac artery to get below the second aneurysm. Because of the walled-off perforation attached to the vena cava, this posteriolateral segment of the aneurysm was left intact. Following the resection of the aneurysm a dacron polyethylene prosthetic graft was inserted to the right to the right internal iliac artery, the left common iliac artery and the aorta.

The right external iliac artery had been clamped off for one hour and the left common iliac artery had been clamped off for one hour and 55 minutes. The circulation of the left colon was not impaired at any time during the operation by the ligation of the inferior mesenteric artery. The peripheral pulses were good and the extremities were warm and dry. At the termination of the operation the blood pressure was 80/50 and the patient received six pints of blood postoperatively.

During the next week, the blood urea nitrogen ranged from 49 to 28 milligrams per cent. The patient had an afebrile course and was out of bed and ambulatory on the fifth postoperative day. He was discharged from the hospital on the 17th postoperative day.

The pathologic report revealed arteriosclerotic aneurysm of the aorta measuring 15 centimeters by 9 centimeters. The secondary aneurysm of the iliac artery measured approximately 5½ by 2 centimeters. The defect caused by the portion of the wall left attached to the vena cava measured 6 by 3 centimeters. The aneurysm was found to be completely filled with dark brown and pale brown tissue and the central portion was relatively soft.

Atherosclerosis is the predominant cause of aneurysms of the abdominal aorta, as noted by Maniglia and Gregory.[4] This is also reported by Estes.[2]

A recent study by DeBakey and associates [1] disclosed that 986 out of 1,281 aneurysms of the aorta which were operated on were located in the abdominal portion. For the most part, these aneursyms arise below the renal arteries.

Pathologically, there is evidence of arteriosclerotic degenerative mural process. There may be calcific and atheromatous changes in the dilated peripheral wall with a lamina ed thrombus. When this thrombus undergoes liquefaction necrosis it may contribute to eventual rupture.

An expansile, pulsating mass associated with pain in the upper abdomen, lower back and lower extremities are characteristic clinical manifestations. Pain may indicate that the aneurysm is growing rapidly. When the mass becomes immobile and tender and/or there is back pain, rapid enlargement of the aneurysm with impending or actual perforation and retroperitoneal hemorrhage must be considered pathognomonic.

Most surgeons feel that aortography is unnecessary and that the usual plane film of the abdomen, especially the lateral projection, may demonstrate calcification in the wall of an aneurysm.[1]

Untreated, this condition presents a grave prognosis. Kampmeier [3] reported 31 deaths out of 38 cases as a result of retroperitoneal hemorrhage. Estes [2] disclosed the striking fact that once the diagnosis of aneurysm has been made, one-third of the patients are dead within a year.

Numerous complications are associated with abdominal aneurysm. Less common is the complication of gastrointestinal bleeding, and more confusing to the physician are complications associated with the genito-urinary tract. As noted by Pinck [5] pressure effects from com-

plications of an aneurysm may simulate renal shut-down, compression of renal vessels, uremia due to expansion or dissection of the aneurysm or occlusion of the ureters.

SUMMARY

A CASE of abdominal aneurysm with walled-off perforation, admitted with azotemia, vomiting and non-pulsating abdominal mass and negative x-rays of the abdomen is presented. Of primary importance is an early diagnosis so that surgery may ameliorate this disease. Of interest is the sharp pre-operative drop in hemoglobin and hematocrit, the abdominal mass enlarging and becoming pulsatile, and the drop in azotemia when the patient was put at bed rest. One may conclude that the rapid growth of the abdominal aneurysm, which became tender and was associated with back pain, may have been due to the perforation, and that the drop in hemoglobin and hematocrit was commensurate. The probability of decreased pressure on the renal vessels by bed rest causing the subsequent sudden drop in azotemia seems to be the most valid explanation.

1300 East Landis Avenue (ENM)

BIBLIOGRAPHY

1. DeBakey, Michael E.: Quoted by George L. Jordan, M.D. in an address at Medical Science Day, Silver City, N. Mex., July 29, 1961.
2. Estes, J. E., Jr.: *Circulation*, 2:258 (1950).
3. Kempmeier, R. H.: Annals of Int. Med., 12:624 (1938).
4. Maniglia, Rosario and Gregory, John E.: Archives of Pathology, 54:298 (1952).
5. Pinck, Bernard D.: Journal of Urology, 85:798 (1961).
6. Steinberg, I., Finby, N. and Evans, J. A.: Am. J. Roentgenology, 82:758 (1959).

Immediate Treatment of Snake Bite

Whiskey is *not* the therapy of choice in the immediate management of snake bite. Coming from Florida where they know about such things (snake bite, not whiskey) Evans and Farrell *Journal of the Florida Medical Association*, April 1962, page 885) list incision and suction as the first step. Then a tourniquet is applied, and attempts are made to relieve pain. Antivenin should be administered. Ice bags around the area are helpful but the whole limb must not be immersed in ice. *Do not give whiskey* or any other form of alcohol, warn the Florida practitioners. If oral fluids seem indicated, give coffee. The limb, of course, should be immobilized and this must be kept in mind when ordering the patient transported.

Safe Drugs for Safe Flying

The use of drugs in flying continues to be of paramount importance (in the Air Force). The flight surgeon should advise, not only aircrew members, but also allied medical personnel that no medication will be taken by aircrew members except under the direct supervision of a flight surgeon. Systemic medications will not be prescribed for pilots unless the individual is grounded for the duration of the effective drugs. Aspirin, APC's, and similar medications may be prescribed without prescription only if the primary disease process is not in itself an adequate cause for grounding. In general, no drugs will be used by an individual while on flying status.—

U.S. Air Force *Medical Service Digest*, October 1962.

Sidney Keats, M.D.

Newark

The Pathology of Trauma in Disability Evaluation

How can a doctor measure disability in percentage terms? One suggested plan is here offered by Dr. Keats.

In New Jersey, workmen's compensation is based principally upon the concept of compensation as a replacement for bodily injury, rather than as damages for loss of earnings. The extent of the bodily damage is used for the evaluation of the *reduced* earning capacity. Theoretically, this may be inadequate. However, it is a practical method. Factors such as age, sex, occupation, economic and social conditions, and opportunities for employment may influence the ultimate loss of earnings in the injured workman. These factors are too variable and too unwieldy to set up as uniform scales of equitable compensation. So the principle of determining the loss of earning capacity by the extent of bodily injury has been adopted almost universally. As in the diagnosis of disease, the determination and evaluation of disability involves the knowledge of certain basic principles.

The basic consideration is the *patient* and his *disability*. The evaluation of any disability is based then on the qualitative and quantitative analysis of the subjective complaints and the objective loss of function. Complaints and loss of function following injury must be consistent with basic concepts of anatomy, physiology, and changes in the integrity of tissue. An equitable assessment of disability can be insured only by a complete understanding of the consequences of the traumatic injury. These are governed by biophysical laws. There is a definite relationship between the natural physical effect of a causative agent and the pathologic sequelae of mechanical trauma which ensues.

The Biomechanics of Trauma

The relationship between the type of injury and the effect on living tissues depend on the *biomechanics* of trauma. The effect of a blow on living tissue depends on the latter's size, shape, and mass. A sharp mass causes a cutting effect on tissues, while a flat or round mass may have a compressing or puncturing effect depending on its size and its velocity. Internal traumatic forces may be muscular or visceral. Muscular forces may include back strains from heavy lifting, or the rupture of a muscle from sudden effort, such as a rupture of the plantaris muscle. The effect of the traumatic force on living tissue will depend not only on the nature of the forces but also on the distance, velocity, and frequency—such as the constant vibration of a trip hammer.

Tissues may be compressed, sheared, extended, bent or twisted. In each case there is a rearrangement of the component units of the matter. If the rearrangement is incomplete, elasticity is impaired. If the elastic limit of

the tissue is passed, either the material will break or it will be deformed permanently. The elasticity of muscles is very high. Nerves have a greater resistance to fracture. The physical properties of tissues vary with different individuals as modified by adaptation, mode of living and disease.

SEQUELAE OF TRAUMA

DISABILITY evaluation represents a *quantitative* diagnosis as opposed to the usual pure *qualitative* diagnosis. We are concerned with the determination of the extent, or the quan ity of the existing pathology, and the reciprocal loss of function which it represents.

The effects of physical forces on living tissues may be classified in two major groups of trauma: (A) compression, and (B), *solution of continuity*. Contusions, for example, are included within the scope of trauma by compression. Severe stress beyond the elastic limit of tissue may break it and cause a solution of continuity. This break in continuity may be preceded by other changes as serious as the dissolution itself.

The pathologic process that results from the application of injury to living tissue is the *reaction of inflammation*. This has been described by Ewing as characterized by (1) degeneration or death of tissue cell, (2) changes in circulation, (3) exudation, (4) secondary degeneration or death of tissue and (5) growth of new tissue. In most injuries, all these phenomena are present. One phase may predominate. The resulting pathology depends on the nature of the etiologic agent and the degree of reaction. Repair is carried out by an increase in the number of cells. This is determined by the external irritant and by the removal of tissue tension which limits the growth of cells.

There are two forms of *regeneration*: *Reparative* regeneration as in the ordinary closure of a gap in continuity—the simple scarring of the skin and *hyperplastic* regeneration—which represents an increase in the number of tissue cells necessary for repair which exceeds the demands—keloidal scar.

END-RESULTS OF TRAUMA

THE end-result of the changes occurring in the tissues permanently alter the structure and function of the involved area.

1. *Skin*—Whenever there is a loss of tissue as a result of compressive trauma or from a solution of continuity, it is replaced by scar tissue. Cutaneous wounds may heal by primary union or by granulation tissue. In wounds healing by granulation tissue, there is considerably more tenderness because of newly-formed blood vessels.

1. One of the chief characteristics of scar tissue is *tenderness*.
2. Scars may cause pain by compression of a nerve structure by contiguity, or by inclusion of nerve tissue when scars retract.
3. The retractibility of the scar may inhibit the normal function of such neighboring structures as mus les or joints.
4. The scars may adhere to neighboring structures such as tendons, muscles, ligaments and joints.
5. Scars tend to break down. This may be followed by ulceration.
6. In some individuals, the regenerative process may proceed beyond the normal demands and form an excess of scar tissue known as a keloid. Keloids may ulcerate and even become carcinomatous.
7. The cosmetic result of scars may be a handicap both economically and socially. Disfiguring scars may prejudice against employment. These scars, although not involving a true loss of function, may prove to be seriously disabling.
8. The location of the scar may be of prime importance in its relation to functional disability. These include scars on the sole of the foot, the palm of the hand, and over an articular joint.
9. Contracted scars may cause more difficulty than linear scars.
10. The depth of the scar may extend beyond the skin, to muscle, tendon, fascia, nerves and blood vessels. The compression or inclusion of these structures will cause pain and disability.
11. Scars in Negroes may be white, avascular, with considerable loss of pigment.

2. *Fascia*—Injury to the fascia results in scar tissue formation and adhesions which prevent the smooth gliding movement of underlying s'ructures. Injury to the fascia may cause more disability because it is more deeply placed and in closer contact to moving structures.

3. *Muscle*—Muscle may be minutely, partly, or totally ruptured. The regeneration of muscle tak s place by scar tissue formation which causes a loss of function of the tissue involved. The loss of function follows a shortening or

loss of contractility of muscle, interfering with its normal physiology. This may cause pain. Pain may also be caused by compression of the nerve end-organs in the muscle by scar tissue. The stretching, and tearing of small muscle fibrils is known clinically as a *strain*.

4. *Joints*—Injuries to joints are characterized by a limitation of motion. This limitation of motion may result from involvement of the structures within the joint itself, or from outside the joint. *Sprains* represent injuries to the joint capsule or the ligaments about the joint. Here motion is restricted by adhesions and the scarring of the soft structures. The joint may become inflamed by trauma. The inflammation results in changes in the synovial lining of the joint which may produce thickening, or the secretion of excess amounts of synovial fluid. The thickened synovial membrane, and the overstretching of the joint capsule and ligaments by excessive joint fluid causes limitation of joint motion, instability of the joint, and atrophy of the adjacent musculature.

The same type of injury does not have the same effect in all persons. Emotional and mental status, economic and social factors, and the person's educational background, all contribute to the effect of an injury on the individual. How then can disability be measured when there are so many variables? Structural change and functional loss then, are the reasonable criteria for the evaluation of permanent disability which meet the demands for disability standardization.

24 Commerce Street

Gynecologist Booklet for the Public

Though people are generally aware of the various medical specialties, they often are vague about their specific nature. The American College of Obstetricians and Gynecologists clears up some common misunderstandings about its specialty area with an informative pamphlet titled "What Is a Gynecologist?" Outlined briefly are the functions of the gynecologist and obstetrician, the importance of periodic gynecologic examinations for women, and how to find a qualified gynecologist. The pamphlet is available in quantity from the American College of Obstetricians and Gynecologists, 79 W. Monroe St., Chicago 3.

Psychoanalysis and the TV Western

Last week I received a letter from Barney Smith who is in Hollywood producing television shows. He wrote:

"As you know, the three big things in television now are doctor programs, westerns, and psychiatry. We're going to combine all three of these into a new type program. It's going to be all about this doctor, who is also a psychiatrist, and the fastest draw in the West, and he is going to be rampaging in Montana in the 1860's.

"We're in the first production. These guys are about to hang this kid for cattle rustling, cheating at cards, and murdering his mother (the old Oedipus complex with a new twist). Just then, Hop-Along Freud rides in, shoots down the rope from the tree, and says, "You can't do this. This kid isn't bad. He's just sick, sick, sick. What he needs is psychoanalysis. And right then and there Hop-Along pulls out his rubber inflatable couch, pumps it up, and psychoanalyzes this kid. At the fade-out, this kid is a reformed character, giving out candy to children, and babysitting while everybody else goes to the saloon.

"Now we need a medical consultant. So stop playing for peanuts in that cowtown, and hop out here on the next plane. It's the chance of a lifetime. As ever, Barney."

My reply: "Dear Barney, While reading your letter I had a heart attack, perforated my ulcer, and my arches fell. You'll have to get someone else. Regretfully, Old Buddy."

—A. H. Chapman, M.D., in *Greater Kansas City Medical Bulletin*, November 17, 1962.

Trustees' Meeting: October 20, 1963

A regular meeting of the Board of Trustees was held at the Executive Offices on October 20, 1963. Detailed minutes have been sent to each component society for the information of the members. A summary of the significant actions of the Board follows:

Medical Quackery Congress . . . Authorized Dr. S. William Kalk of Newark to attend this congress in Washington, D.C., October 25 and 26.

Traffic Safety . . . Designated Dr. Jesse McCall of Newton to attend the regional workshop on problems in driver licensing and other medical aspects of traffic safety, sponsored by the American Association of Motor Vehicle Administration and the United States Public Division of Accident Prevention, to be held in Harrisburg on December 3, 4 and 5.

Smoking and School Children . . . Authorized the purchase of reprints of the article "Smoking Habits of School Children" by Dr. Seymour F. Kuvin of Morristown (September 1963 JOURNAL), for distribution to the PTA organizations throughout New Jersey.

Audit Committee . . . Received the report of the Audit Committee, as follows:

> The report was carefully examined in order to determine any deficiencies that might be reported to the Board, to look for any errors by the auditors and to carefully probe our collective business practices to the end that suggestions for improving them might be made. Mr. Teunon, representing the auditors, was very helpful in explaining the matters to the committee and entered into the discussions with helpful suggestions. The committee is pleased to report that to the best of its knowledge and belief this audit is fair and complete reflecting the fiscal status of the Society and that no evidence of discrepancies or mishandling has been discovered.
>
> The committee gave particular attention to the specific items in the audit — Annual Meeting, Journal, Medical Student Loan Fund, Reserve Accounts, Contingent Account, Investments, and Fiscal Year vs. the Calendar Year — and suggested that its observations on these items be referred to the Committee on Finance and Budget.

Child Safety Week . . . Adopted the recommendation of the Child Health Committee, as follows:

1) That Governor Hughes be requested to proclaim the first week of April 1964 as "Child Safety Week."
2) That each component society be furnished with community child safety program kits for use in establishing child safety committees.
3) That the Committee be allotted space at the 1964 Annual Meeting for the scientific exhibit "Learning Processes."

Eye Health Programs . . . Approved the following recommendations of the Conservation of Vision Committee:

1) That the annual Eye Health Screening Program be continued in the fall of 1964.
2) That the Eye Health Workshops be continued, in cooperation with the New Jersey Commission for the Blind.

Tuberculosis Control . . . Approved the recommendation of the Council on Public Health that the following paragraph be added to Resolution No. 13 (adopted by the 1963 House of Delegates):

> Resolved, that The Medical Society of New Jersey emphasizes and endorses the principles of State payment of full cost in city as well as county hospitals for tuberculous patients.

Medical Women's Association . . . Approved the recommendations of the Council on Public Health, as follows:

1) That a committee be appointed to work with the New Jersey branch of the American Medical Women's Association, to revise health instructions in schools to include the subject of venereal disease and personal health problems.
2) That NJMWA consider the inclusion of "goof balls" and narcotics as part of their project and as the subject for a teaching reference guide.

Cigarette Smoking and Lung Cancer . . . Approved the recommendation of the Council on Public Health that MSNJ adopt a statement limited to cigarette smoking and cancer of the lung similar to the resolution of the Pennsylvania Medical Society and the statement of the New Jersey State Department of Health.

Insurance Rates . . . Requested that the Chairman of the Medical Defense and Insurance Committee prepare an item for inclusion in the *Membership News Letter*, explaining that the committee is "working and discussing with American Mutual Liability Insurance Company the experience and the possibility of establishing our own rates."

Hearing or Trial Reimbursement . . . Approved the endorsement of the Medical Defense and Insurance Committee to the members' policies to provide reimbursement for the insured's attendance at a hearing or trial in the sum of $100 per day not to exceed a total sum of $2,500 ("day of attendance at any hearing or trial" defined as attendance for more than three hours; additional premium, $2).

Accident and Health Extended Coverage . . . Approved the Medical Defense and Insurance Committee's endorsement of the new Nationwide disability policy, as follows:

A communication from E. & W. Blanksteen Agency reported that they have successfully completed state-wide enrollment to achieve the 50 per cent quota required to include impaired risks under the Nationwide Insurance Company plan of accident and health insurance, (basic coverage 5 years accident—2 years sickness.)

Nationwide will issue an extended coverage policy to provide accident benefits for lifetime and sickness benefits from 2 years to 7 years. New applicants would be limited to age 55. The Nationwide policy would be the same and at the same rates as the National Casualty extended coverage policy except that the National Casualty policy would accept new applicants to age 60. Both policies terminate at age 65.

Advisory Council . . . Nominated (to the Commissioner of Education) Dr. Jesse McCall for reappointment to the Advisory Council on the Emotionally Disturbed Child of the State Department of Health.

New Jersey Bond Issue . . . Reaffirmed its action of June 16 "that the Society take no position on the Bond Issue" and that Leonard F. Newton of Opinion Research Corporation in Princeton—who cited MSNJ as one of the opponents of the Bond Issue—be so informed, with a copy to Governor Hughes.

Welfare Council . . . Named Dr. Peter J. Guthorn of Asbury Park as the Society's official delegate to the New Jersey Welfare Council's annual conference in Asbury Park on October 29, 30, and 31.

Psychosomatics in Reverse

From time to time this JOURNAL publishes a psychosomatic profile. We wish to highlight the fact that organic illness has emotional effects and may have emotional components. Less obvious, but implicit in the psychosomatic doctrine, is the concept that emotional disorders are often manifested through physical modalities—even through actual chemical or structural change. Thus, if a patient has to suppress anger or rage, he may pour out an excess of acid into the stomach and exhibit gastric hypermotility. The combination can produce a peptic ulcer. If the patient is treated only by psychiatric technics, the ulcer may heal. Unfortunately, it may also rupture (and induce a fatal peritonitis) before it heals if the ulcer itself is not medically or surgically treated.

The psychosomatic doctrine has seized our imaginations to such an extent that we are now facing the opposite danger: ignoring of organic or structural disease because of the existence of manifest emotional problems.

The reality of this danger is highlighted by the findings of Phillip Rossman* who turned up 115 cases of organic disease in patients diagnosed as neurotic. Twenty-five of these "neurotics" died of cancer within a year. In Rossman's series, hyperthyrodism was misdiagnosed as anxiety reaction and Addison's disease as neurasthenia. One received electroshock for a depression that as it turned out was due to brucellosis. (You'd think that the high temperature of undulant fever would make it easy to diagnose; unhappily its symptoms can include irritability, depression, insomnia, and generalized pains.) Several brain tumors were branded as neurotic reactions. Abdominal pain and backache associated with malignancies were missed because of negative x-rays.

Naturally a sick person will have emotional symptoms. And everybody has emotional problems which can be found without too much investigation. After all, there is no such thing as a negative psychiatric examination. But positive psychiatric findings should not lull us into assuming that there is no disease of the structure.

*Rossman, Phillip L. in the August 1963 GP.

Announcements • • •

Emergency and Disaster Medical Service Seminar

An intensive two-day course in all aspects of emergency and disaster medical and health services is now being offered in Newark at the Essex House under the joint sponsorship of The Medical Society of New Jersey and the U. S. Public Health Service. The seminar will take place on Tuesday, February 18, from 9:15 a.m. to 5:00 p.m. and on Wednesday, February 19, from 9:00 a.m. to 4:00 p.m.

Subjects covered will include the medical effects of nuclear weapons, the handling of mass casualties, the epidemiologic aspects of disaster, the management of burns, and emotional reactions to disaster. More details may be obtained from Jack R. Karel, M.D., 115 North Avenue, Hillside, New Jersey.

Allergy Course in Miami

A graduate course in allergy will be offered at the Americana in Bal Harbour, Miami Beach, Florida, during the week of March 1. For further information, write to John D. Gillaspie, M.D., at 2141 Fourteenth Street, Boulder, Colorado.

Want to Go to the Northwest?

A six-office building has been opened for four physicians and two dentists. Building is modern, air-conditioned, equipped with x-ray unit and special laboratory facilities. Clinic group and location have been established since 1949. It is in a suburb of Portland, Oregon, within 9 miles of three major Portland hospitals and the University of Oregon Medical Schools. Climate, scenery, recreational opportunities, school facilities, and lovely homes leave little to be desired.

This clinic needs two new physicians. They prefer two general practitioners, or one general practitioner and one internist. This is an excellent opportunity to pick up the practice of two who are leaving. This operates on an association basis, sharing calls and basic expenses. Affiliations are in Portland in accredited hospitals.

Details may be obtained by writing Everett A. Sorensen, M.D., Tualatin Clinic, 495 Canyon Road, Beaverton, Oregon.

Cardiology Course Available

Starting Thursday, January 9, and for eight consecutive Thursdays, the Pennsylvania Hospital will offer readers of this JOURNAL an intensive course in cardiology running from 2:30 p.m. to 9:00 p.m. For details, write to the Director of Graduate Education at the Pennsylvania Hospital, 800 Spruce Street, Philadelphia, Pennsylvania.

Conference on Ophthalmology

The Annual Clinical Conference of the Wills Eye Hospital will be held on February 13, 14, and 15, 1964. For details write to J. W. Hallett, M.D., at the Wills Eye Hospital, 1601 Spring Garden Street, Philadelphia 30, Pennsylvania.

Symposium on Smoking

An all-day meeting on medical aspects of smoking is scheduled for Wednesday, January 22, at New York's Hilton Hotel, 53rd Street and Avenue of the Americas. The following topics will be covered: deterrents to smoking, smoking and pregnancy, smoking and its effects on the respiratory tract, the effects of smoking on blood chemistry, and the smoking behavior of school children.

This is a symposium sponsored by M. R. Thompson, Inc., of New York. For more details, write to the Medical Director of the Company: Dr. S. J. London, M. R. Thompson, Inc., 711 Fifth Avenue, New York, 10022.

Book Reviews

Moral Treatment in American Psychiatry. J. S. Bockhoven, M.D. New York, 1963, Springer. Pp. 116 ($3.00)

The phrase "moral treatment" refers to the social-emotional approach to mental illness that characterized small American mental hospitals between 1820 and 1860. The practice then was to try to understand what was worrying the patient, to encourage group meetings, to provide patients with an environment that was both compassionate and esthetically appealing. Shortly after the Civil War this was replaced by a medical rather than a social model of mental illness. Under the impact of pathology, the late Victorian alienist looked through his microscope for some bacteria or some change in brain tissue to explain the psychosis. The hospitals then seemed more interested in autopsy material than in understanding the patient. Concomitant with this, was the cult of incurability; the idea that mental illness, depending on brain pathology, was a one-way street. This myth gave hospital doctors the comfortable feeling that no one could blame them for poor recovery rates. Not until after the turn of the century was this cult replaced by the modern and hopeful attitude that visualizes mental illness as a badly learned way of life. Dr. Bockhoven tells this story with clarity, compactness and interest.

ABRAHAM LEFF, M.D.

Current Diagnosis and Treatment. Henry Brainerd, M.D., Sheldon Margen, M.D. and Milton Chatten, M.D. Los Altos, California, 1963, Lange Medical Publications. Pp. 843. Soft cover. ($9.50)

Soft-cover, offset-printed books are becoming increasingly popular in medicine. Since medicine changes rapidly, a book several years old may be obsolete. One hates to discard an expensive, hard-bound volume. One obvious solution is to issue frequent editions of offset-printed soft-bound books. However, the days of the 25 cent paper-back seem gone. This soft-cover volume retails at $9.50. Since lithograph reproduction is harder to read than the traditional letter-press kind of printing, some of the advantage of this kind of reproduction is lost.

The text follows the traditional pattern of the "outline" type of volume—an extremely compact treatment of symptoms, diagnosis and treatment. An enormous amount of material is thus packed into these 843 pages. A useful 30-page manual of toxicology is included. Also offered is a brief and interesting text on "unestablished drugs" and an almost unique roster of recently introduced and recently withdrawn drugs. Also included is a tabulation of chemical analysis of body fluids, height and weight norms, blood values, and other tabular miscellany. All in all, this is a good reference work for the general practitioner, and for the specialist who wants to keep handy a one-volume manual covering the rest of medicine.

FELIX A. UCKO, M.D.

Synopsis of Ear, Nose, and Throat. By Robert E. Ryan, M.D.; William C. Thornell, M.D.; and Hans von Leden, M.D. 2nd Edition. St. Louis, 1963, Mosby. Pp. 425. ($7.50)

This is the 2nd edition of a synoptic type of book directed mainly to interns, medical students, and general practitioners. This book was divided into four sections: the Ear, the Nose and Paranasal Sinuses, the Pharynx, and the Larynx. This little volume is easy to read and the index is excellent. The chapter on Headache is particularly succinct and clear. Most chapters also have excellent summaries. It might have been advisable that the reader be acquainted with what contribution to this book each author made as there are three authors.

This work is an excellent reference book for the beginner first becoming acquainted with the ear, nose, and throat. It is a trifle too synoptic to be of real value to the general practitioner.

HENRY Z. GOLDSTEIN, M.D.

Textbook of Pathology with Clinical Application. Stanley L. Robbins, M.D. Philadelphia, 1962, W. B. Saunders Co. Second Edition. Pp. 1190. Illustrated. ($19.00)

This second edtion of Professor Robbins' text has been enlarged but retains printing which facilitates reading. The text is notable for its presentation, not only of classical pathology but also contemporary pathology. This theme is shown especially in the references, which include current authorities as well as in the presentation of subjects presently under study. An illustration of this is seen in Wegener's granulomatosis, kwashkor, and the presentation of pulmonary alveolar proteinosis.

The author's presentation of neoplasia as the third chapter in his book (before discussing inflammation, repair, and the degenerations) constitutes a distinct break with tradition in the discipline of pathology; but it is handled in a masterful manner, and merits early discussion with the student

of pathology because of the major importance of the subject of oncology to applied pathology.

The case of cervical carcinoma presented to the student at the conclusion of this chapter is an excellent clinical illustration. But it is the reviewer's impression that basal cell hyperplasia and anaplasia of the cervical mucosa are now accepted by most surgical pathologists as a definite precursor of neoplasia in this particular tissue; and for practical purposes this patient would have been treated earlier for carcinoma of the cervix than the author implies.

In the chapter on the nervous system, the contributor, Dr. Foley, writes "The finer angio-architecture of the brain is like that elsewhere, a network of arteries, arterioles, capillaries, venules, and veins, with generous anastomoses. This is in contrast to some of the older views, which held that the arteries of the brain were end-arteries." The reviewer presumes that Dr. Foley can prove his statement.

The illustrations in the book are well done and appropriately placed. In this text the author has accomplished a unique correlation of pathological principles with clinical medicine. The text is a scholarly, timely, and modern presentation of pathology with an excellent subject index. It is recommended to students of pathology as a book which will amply reward their interest. The volume has a freshness about it which is highly commendable.

THOMAS K. RATHMELL, M.D.

Management of the Anxious Patient. Ainslee Meares, M.D., Philadelphia, 1963, Saunders. Pp. 493. ($9.00)

In an essentially "personal approach," Dr. Meares tells us how *he* would handle anxiety in a patient. The book is enlivened by many specific and verbatim samples of what patients say and what doctors should say, in connection with this problem. However, the author does not rely on words. He stresses the more subtle, intuitive, nonverbal (sometimes almost mystical) aspects of doctor-patient rapport. His fundamental idea is this. Early in his history, man (or a prehuman species) functioned pre-rationally, more or less instinctively. Rest, sleep, sedation and day dreaming are examples of a brief return to this epoch. Meares seeks to get the patient to regress this way, seeing this as the most effective way of allaying anxiety. The principal way of doing this is through a process of hypnoidalization—induction of a state of near-hypnosis.

This is an eminently practical book, in spite of the apparently rather abstract nature of these suggestions. The manual is replete with ideas usable by general practitioners in handling what is surely the dominant symptom of our age: anxiety. And it gives interesting food for thought to psychiatrists, too.

HERBERT BOEHM, M.D.

Your Future as a Physician. S. William Kalb, M.D New York, 1963, Richards Rosen Press. Pp. 158 ($2.95)

With warmth and wisdom, the president of our Essex County Medical Society here gives depth coverage to the selection of medicine as a career. Dr. Kalb reviews the motivations behind the desire to study medicine; the courses the student should take in high school and college; the ways of applying for medical school; the costs of medical education; the economics of medical practice; internship; problems in selecting a specialty or remaining a GP. A list of information sources and a roster of approved medical schools is included. The code of ethics of the New York State Medical Society is presented. An interesting chapter on personal qualities desirable in an M.D. pulls no punches. This is an unusually down-to-earth presentation of the topic, available at an unusually down-to-earth price. It is an ideal gift from a physician to the hopeful son of a good patient. Indeed, since there is a thoughtful chapter on women in medicine, it is an inspiring gift to daughters, too.

Dr. Kalb, in a sense, earned the right to author this book. As a founder and National Chairman of Future Physicians Clubs, he has been one of the prime recruiters for our entire profession.

HENRY A. DAVIDSON, M.D.

Current Therapy: 1963. Edited by Howard F. Conn, M.D. Philadelphia, 1963, Saunders. Pp. 775.

A panel of more than 200 practitioners here tell of their "methods" of treating disease. Each section is personalized as "the method of . . ." The editors follow the traditional division of the body into systems and provide separate chapters on the treatment of cardiovascular, digestive, allergic diseases, and so on. The lurch from trade-names of drugs to generic names is somewhat confusing. Thus the index lists "amphetamine in cerebral palsy" for page 489, but Benzedrine® in cerebral palsy refers us to page 490. This, however, is only a venial sin. The value of the book lies in the practicalness of its therapeutic suggestions. Surgical as well as medical methods are described. The contributors are active practitioners and write from experience. The usefulness of the volume is further reinforced by tables of normal laboratory values, common poisons, milli-equivalents and other frequently-needed constants.

ULYSSES M. FRANK, M.D.

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Index 1963

Society established July 23, 1766
Journal founded September 1, 1904

VOLUME 60

JANUARY TO DECEMBER, 1963

Published monthly under direction of the
COMMITTEE ON PUBLICATION

GEORGE B. SHARBAUGH, M.D., Chairman

C. SPENCER DAVISON, M.D.
MARCUS H. GRIEFINGER, M.D.
JAMES J. FITZPATRICK, M.D.
CHARLES H. CALVIN, M.D.

HENRY A. DAVIDSON, M.D., *Editor*
THERESA E. GOEKE, *Assistant Editor*

Editorial Office
315 WEST STATE STREET
TRENTON, N. J.

HOW TO USE THIS INDEX

This is a single alphabetical index. When searching for an original article, look under the first significant word in the title. Authors are also listed alphabetically, with an asterisk (*) to indicate if reference is to an original article. Editorials are indexed by first significant word of title or by subject; book reviews, by title or subject but not by author. City of residence is indicated for authors of original articles.

If you do not bind your JOURNALS, use the table of pages (below) to find the month of issue to which any page citation refers.

The annual reports of the committees and officers of the Society and the Transactions of the annual meeting appear in the July issue.

TABLE OF PAGES

January	1 to 50	August	373 to 412
February	51 to 98	Annual Reports	July JOURNAL
March	99 to 142	Transactions	July JOURNAL
April	143 to 180	September	413 to 456
May	181 to 222	October	457 to 496
June	223 to 254	November	497 to 536
July	255 to 372	December	537 to 578

A

Abdominal Aneurysm with Azotemia—Mattiolo; Cunningham *559
Abdominal Pain, Interpretation of—Thompson *194
Abdominal Wounds—Idris; Ryan; Bazinet *183
Abortion, Deaths Due to—Preece *523
Abortion, Bacteremia in—Bookrajian *520
Abortionist, The br140
Abrams, Jerome, M.D.; Plainfield *474
Academy of Medicine Library 208, June 41A, July 4A, ab509
Accident Prevention br95
Accident Prevention and the Family Physician—Southard *232
Activist Philosophy in Medicine e100
Adenotonsillectomy, Anesthesia for—Lutz *382
Adopted Children, Disclosure to ab30
Aged, Medical Assistance for 404
Agolia, Michael W.† 409
Alcohol and Blood 133
Alcoholic Patients in a General Hospital—Ivey *70
Alcoholics, Help for 42
Allman, Appreciation of Doctor ab245
AMA—ERF Program e53
Amputees, Financial Aid for New Jersey 146
Anaphylactoid Reaction to Bromsulphalein—Salerno; Cherashore; Middleton *435
Anatomy and Nutrition br454
Anesthesia for Adenotonsillectomy—Lutz *382
Anesthesia in Chest Cases—Cox *125
Animals, Research Without e413
Announcements 42, 93, 136, 146, 208, 406, 492, 532, 567
Annual Meeting, 198th 364
Annual Meeting Program, 197th 150
Annual Reports 258
Antibiotic Certification ab462
Anti-Depressant Drug Combinations—Robie *547
Anxiety (Lewis) *524, br219, br569
Art Therapy—Thompson *467
Arthritis Prevention 40
Atrial Septal Defect—Sabety; Masterson; Gelman; Gerard *424
Atlantic City, On the Boardwalk in e143, e181
Auto Accidents and Physicians—Ross *43 e256, e374
Axilrod, Maurice† 216
Ayers, John Raymond† 216

* Original Article
† Obituary
e—Editorial
br—Book Review

ab—Abstract
Annual Reports: July JOURNAL
Transactions: July JOURNAL

B

Bacteremia and Septic Abortion—Bookrajian *520
Bartels, Elmer C., M.D.; Boston, Mass. *474
Barth, Louis, M.D.; Newark *395
Bazinet, P., M.D.; Trenton *183
Beerman, Herman, M.D.; Phila., Pa. *73
Between Us Women br412
Biopsy, Renal 494
Blood Pressure and Longevity ab127
Blue Cross Excessive Hospitalization 450
Blue Shield e99, e182, e414, e457
Bookrajian, Edward J., M.D.; North Bergen *520
Book Reviews 46, 95, 138, 147, 219, 251, 372, 411, 454, 494, 534, 568
Booth, Mrs. Walter S. (Pat); Elizabeth e224
Bornstein, David† 216
Boyd, David P., M.D.; Boston, Mass. *82
Boyd, John B.† 44
Boyer, Charles G.† 452
Boyers, Sidney S., M.D.; West New York *58
Boyes, James Gordon† 409
Brain Cancer—Winter *8
Brauer, Earle W., M.D.; Jersey City *24
Braun, Peter, M.D.; Trenton *504
Breast Engorgement, Hydrochlorothiazide for —Barth *395
Brisco, Margaret, M.D.; Newark *510
Bromsulphalein, Anaphylactoid Reaction to—Salerno; Cherashore; Middleton *435
Brooks, George M.† 533
Brophy, Francis X.† 216
Bull, William J.† 452

C

Cadaver Shortage ab185
Camden County Stroke Project—Florin; Rosenthal *109
Cancer, Breast ab243
Cancer, Detection and Diagnosis br411
Cancer Therapy, Intra-Arterial—Forsberg *11
CARE and Medico Merger 104
Cardiology Classics br138
Carr, Mary† 137
Cell: Normal and Malignant—Miller *439
Cerebral Re-Education, Retino—Rubin *420
Cervix, Carcinoma of the br140
Chemical Warfare Defense ab517
Cherashore, Joel, M.D.; Montclair *435
Chernus, Jack, M.D.; East Orange *128
Chest Injuries, Anesthetic Problems in—Cox *125
Child Abuse, Physicians Responsibilities in e143
Child Protective Services in New Jersey 391
Child Surgery br95
Childbirth, Psychophysical Methods for Relief of br251
Children, Emotionally Ill, Responsibility for —Duffy, Jr. *101
Chirurgeon Kai Cephalurgeon e414
Chronic Fatigue—Nussbaum *499
Cicalese, Gerard, M.D.; Newark *510
Cigarette Smoking 45, 134, 136, 141
Ciliberti, Frank V.† 452
Clark, James F.† 44
Cohen, Burton M., M.D.; Elizabeth *484
Cohn, Sidney, M.D.; Passaic *244
Colitis, Ulcerative, Treatment of—Salvati *105
Colon, Cancer of the—Swerdlow; Ulvestad *518
Colon, Resection of Lesions of—Ryan *480
Committees, Special 528
Communication, On (Lewis) *94
Communications, Medical ab234
Compensation of Interns and Residents 90
Comte Auguste—The "Mad" Philosopher br46
Confidentiality of Medical Information 39, 209
Contact Lens Sales, AMA Name in ab381
Cooling, Gastrointestinal—Heineken *482
Cooper, Howard M.† 409
Cost of Medical Care ab18
Cox, Joseph A., M.D.; Elizabeth *125
Coxsackie and Orchitis—Minzter *463
Crane, Charles G.† 216
Cunningham, Charles, M.D.; Vineland *559

D

Davis, V. Terrell, M.D.; Trenton *545
Death Certificates ab384
Deaths Due to Septic Abortion—Preece *523
Dermatoglyphics br96
Dern, Samuel M.† 409
Discrimination e458
Diabetes Detection in New Jersey 457
Diabetes, Fetal Loss in—Fleming *389
Diagnosis and Treatment, Current br568
Digestive Lower Tract br219
Dinner-Dance 151, 365
Disability Evaluation and Trauma—Keats *562
Disclosure by Physicians 39
Doctors' Dilemmas br140
Doctors in Politics (Karel) e498
Doggett, E. Hugh† 137
Dreams, The Science of br251
Dresdale, Frank C., M.D.; Plainfield *474
Drinking Water and Heart Failure—Braun; Florin *504
Drug Combinations, Anti-Depressant—Roble *547
Drug Eruptions—Beerman *73
Drug Therapy br252
Drugs, Cost of ab202
Drugs in Current Use 1962 br46
Dues—Exempt Members 214
Duffy, Edward P., Jr., M.D.; Belleville *101
Dynasty: A Medical Novel br412

E

Ear, Nose, and Throat Synopsis br568
Education for the Physician, Continuing—Ferrary *539
Educational Exhibits 166
Election and Nominations 350
Electromyography, Indications for—Furey *514
Emotion, Healing Force of e3
Emotions and Muscle, Bone and Joint Disease (Schwarz) *453

1- 50—Jan.
51- 98—Feb.
99-142—March
143-180—April
181-222—May
223-254—June
255-372—July
373-412—Aug.
413-456—Sept.
457-496—Oct.
497-536—Nov.
537-578—Dec.

Emotionally Ill Child, Family Doctor's Responsibility for—Duffy, Jr. *101
Endocrinology br47, br149
Endotracheal Anesthesia: The Choice for Adenotonsillectomy—Lutz *382
Epilepsy and the Law ab69, 218
Epilepsy, Psychosomatic Relationship in (Revitch) *145
Equivalents of Equivalence e51
Eruptions and the New Drugs—Beerman *73
Esophagus, Reconstruction of—Heimlich *65

F

Family Doctor and Mental Health e100
Family Doctor's Responsibility in the Care of the Emotionally Ill Child—Duffy, Jr. *101
Family Physician, Role of—Southard *232
Fatigue, Chronic—Nussbaum *499
Ferrary, Paul B., M.D.; Paterson 135, *539
Fetal Loss in Diabetes—Fleming *389
Field, Frank L.† 92
Fleming, Joseph A., M.D.; Montclair *389
Florin, Alvin A., M.D.; South Orange *109, *504
Fluoridated Water and Blood Glucose (Wolfe) 43
Fluoridation and Caries ab23
Fluoridation, Position on 36
Folic Acid in Vitamins—Haynes, Jr. *477
Follette, William J., M.D.; Englewood *542
Forensic Medicine br96
Forsberg, Roy T., M.D.; Elizabeth *11
Freedom, Fading—Nevin *86
Frostbite ab34
Furey, Charles A., M.D.; Lakeland *514
Furst, William, LL.B.; Newark *229
Furst, William, M.D.; East Orange *229
Fussing and Feuding e1
Future of Physicians br569

G

Garber, Robert S., M.D.; Belle Mead *235
Gastric Cooling—Heineken *482
Gastroenterology, Current br147
Ged, Archie K.† 409
Gelber, Isaac, M.D.; Elizabeth *54, †452
Gelman, Hugo O., M.D.; Orange *241, *424
Generic Name Prescribed e51
Gerard, Franklyn P., M.D.; East Orange *424
Geriatric Surgery—Roberts *15
Giambra, Santet† 44
Gibbs, Jonathan C., Jr., M.D.; Jersey City *392
Giordano, William C., M.D.; Ridgefield *186
Glaucomas, Diagnosis and Therapy of the br47
Golden Merit Award 177, 248
Goldmacher, Herman† 533
Goldstein, Henry Z., M.D.; Newark *431
Gordon, Abel† 137
Gout in Women ab23
Graddick, Lester† 533
Greifinger, Marcus H., M.D.; Newark 246
Grieco, R. V., M.D.; Jersey City *392
Grossbard, Paul, M.D.; Passaic *244
Group Practice, Balance Sheet for ab7
Gynecologic Endocrinology br148

H

Haase, F. Robert, M.D.; Neptune *121
Haggerty, Francis F.† 92
Hair Spray Can Be Dangerous ab85
Haley, Paul† 216
Handicapped Children, Clothing for ab81
Handwriting, Doctors' e374
Hanfling, Seymour L., M.D.; East Orange *555
Haynes, William F., Jr., M.D.; Princeton *477
Head and Neck Surgery, An Atlas of br251
Hearing Problems of the School Child—Goldstein *431
Heart Attack, Service After ab207
Heart Failure and Drinking Water—Braun; Florin *504
Heimlich, Henry J., M.D.; New Rochelle, New York *65
Heineken, Theodore S., M.D.; Glen Ridge *482
Hemolytic Anemia in Infectious Mononucleosis—MacPherson *13
Hip Dysplasias in Children—Reilly *117
Home Care Program 213
Homer, LeRoy, M.D.; Woodbridge *115
Horland, Aaron H.† 409
Hospital Administration, Modern Concepts of br147
Hospital Costs—Kent *459
Hospital Dispensing ab513
Hospital-Physician Relationships 37
Hospitalization and Blue Cross 450
House of Delegates 151
How to Multiply Your Dollar e53
Hunter, John: The Reluctant Surgeon br534
Husted, Samuel H.† 92
Huthsteiner, George, M.D.; Van Nuys, Calif. 135
Hydrochlorothiazide for Postpartum Breast Engorgement—Barth *395
Hypersomnia, Psychogenic Causes of (Revitch) *541
Hyperthyroidism Tested With Radioactive Iodine—Gibbs, Jr.; Grieco; McKeown *392

I

Iconoclasm, A Plea for Constructive—Wegryn *5
Idea Behind the Word e458
Idris, M., M.B.; Trenton *183
Index 570
Index of 1963 Transactions 257
Infants, Institutionalization of—Davis *545
Infants, Stevens-Johnson Disease in—Hanfling; Nevius *555
Infertility Problems—Israel *19
Infusion Chemotherapy for Brain and Neck Cancer—Winter *8
Insulin Combinations, Zinc—Robins *428
Interns, Compensation of 37, 214

* Original Article
† Obituary
e—Editorial
br—Book Review

ab—Abstract
Annual Reports: July JOURNAL
Transactions: July JOURNAL

Israel, S. Leon, M.D.; Phila., Pa. *19
Ivey, Evelyn Parker, M.D.; Morristown *70

J

Joffe, Phillip M.† 44
Johnson, G. Leonard† 533
Jonas, August M.† 137
JOURNAL advertising rates 133
JOURNAL cover, new e144
JOURNAL Contributors, Suggestions to 448

K

Karey, Jack R., M.D.; Hillside e498
Kartagener's Syndrome—Kroeker; Boyd; Schwarz, Jr. *82
Kaufman, Jerome G., M.D.; Maplewood e223, *225, 246
Keats, Sidney, M.D.; Newark *562
Kent, Frank K.; Trenton *459
Kessler, Fred A.† 44
Kimmel, M. Leonard† 216
Kramer, Samuel E.† 409
Kroeker, Edwin J., M.D.; Boston, Mass. *82
Kuvin, Seymour F., M.D.; Morristown *415

L

Laboratory Medicine br148
Legal Responsibility in Research—Furst; Furst *229
Legislation 210-212, 526
Letters to THE JOURNAL 43, 135, 218, 488
Lewis, Robert L., M.D.; Elizabeth *54
Lewis, Sanford M., M.D.; Newark *94, 524
Liaison Representatives 528
LSD As a Therapeutic Tool—Schmiege, Jr. *203
Lung Function Testing in the Office—Cohen *484
Lutz, Joseph F., M.D.; Livingston *382

M

MacPherson, Donald J., M.D.; Oradell *13
Mail-Order Pharmacies ab234
Malpractice Law Dissected for Quick Grasping br494
Manno, Peter† 452
Margolin, Samuel J.† 44
Masterson, John E., M.D.; East Orange *424
Mattioli, E. N., M.D.; Vineland *559
McKeown, James E., B.A.; Jersey City *392
Medical Assistance for the Aged in New Jersey 404
Medical Assistants Association 249
Medical Defense Course ab517
Medical Jurisprudence and Toxicology br251
Medical Service Administration 325
Board, Nominations for 215
Request for Funds 35
Medical-Surgical Plan 328
Board, Nominations 215
Open Discussion at Annual Meeting 352
Statement on Supreme Court Decision 403
Megacolon, Toxic—Gelber; Lewis *54
Membership Directory 527
Mental Health and Family Doctor e100
Mental Health in the Metropolis br139
Methdilazine Intoxication—Homer *115
Middleton, Elliott, M.D.; Montclair *435
Military Dependents, Care of 208
Miller, Howard B., M.D.; Fair Lawn *439
Minzter, Albert, M.D.; Elizabeth *463
Molitch, Matthew, M.D.; Atlantic City *489
Mononucleosis, Anemia in—MacPherson *13
Moral Treatment in American Psychiatry br568
Motion Picture Theatre, 197th Annual Meeting 153
Multiple Vitamins Containing Folic Acid—Haynes, Jr. *477
Mushrooms, Deaths from 208
Music Therapy—Thompson *467

N

Neck Cancer—Follette *542
Neurologic Diagnosis br220
Nevin, Richard I.; Trenton *86
Nevius, William B., M.D.; East Orange *555
News Releases, Policy Decision 91
Nicoll, George L.† 137
Nicotine Addiction (Rosen) 43
Noguera, J. T., M.D.; Asbury Park *121
Non-Equivalence of Equivalents e51
Nussbaum, Harvey E., M.D.; Newark *499

O

Obituaries 44, 92, 137, 216, 409, 452, 493, 533
O'Brian, Jeremiah† 137
Obstetrics br46, br252
Ocular Pathology in Reserpine Sensitivity—Raymond *417
Ointments, Microbiology of ab481
Oophorectomy in Cancer of the Bowel—Swerdlow; Ulvestad *518
Operating Nurse, Logic of br412
Ophthamology, Textbook of br411
Opportunities for Physicians in FTC 451
Opticians and Optometrists 213
Orange Publishing Company e538
Orchitis and Coxsackie Virus Infection—Minzter *463
Osteopaths in Hospital 450
Osteoporosis, Treatment of—Tillis *200

P

Padden, Aloysius† 410
Pain, Abdominal, Interpretation—Thompson *194
Palladino, Alexander† 217
Parry, Oliver K.† 533
Pathology e52, br138, br147, br568
Pathology of Trauma in Disability Evaluation—Keats *562
Pediatric Diagnosis br534
Perforated Abdominal Aneurysm—Mattioli; Cunningham *559

1- 50—Jan.
51- 98—Feb.
99-142—March
143-180—April
181-222—May
223-254—June
255-372—July
373-412—Aug.
413-456—Sept.
457-496—Oct.
497-536—Nov.
537-578—Dec.

Perlberg, Harold† 44
Personal Property Tax 274
Pesin, Edward; Newark *397
Pfaff, Francis O.† 45
Pharmacology br139, br534
Physician-Hospital Relationship 37
Pindar, William A.† 45
Placebos and Mental Patients ab108
Plea for Constructive Iconoclasm—Wegryn *5
Pleural Effusions—Ream *375
Plinke, Fritz W.† 493
Poliomyelitis Immunization 132, 525
Post, Charles Francis† 493
Postpartum Psychiatric Problems br149
Preece, John D., M.D.; Trenton *523
Pregnancy in Cushing's Syndrome—Abrams; Dresdale; Bartels *474
Pregnancy, Heterotopic—Cohn; Grossbard *244
Privileged Communication 39, 209
Professional Service Corporation Act—Pesin *397
Progesterone in Pregnancy br139
Psychiatric and Alcoholic Patients in a General Hospital—Ivey *70
Psychic Injury e497
Psychoanalysis, Common Sense about br454
Psychoanalysis and Religion br48
Psychogenic Causes of Hypersomnia (Revitch) *541
Psychologists under Civil Service 133
Psychosomatic Geriatrics (Molitch) *489
Psychosomatic Medicine, New Frontiers in—Chernus *128
Psychosomatic Profile 94, 145, 453, 489, 524, 541
Psychosomatic in Reverse 566

R

Radiation Protection 218, 228
Radiation Therapy in Skin Disease—Brauer *24
Radioactive Iodine in Treatment of Hyperthyroidism—Gibbs, Jr.; Grieco; McKeown *392
Radiodermatitis ab185
Radioisotope Training 231
Raymond, Louis F., M.D.; East Orange *417
Ream, Charles R., M.D.; Elizabeth *375
Reference Committees and Reports 152, 335
Reilly, John J., M.D.; Elizabeth *117
Reisfield, Donald R., M.D.; New Brunswick *385
Relative Value Scales for Radiology ab399
Religion and Medicine Committee 525
Religion and Psychoanalysis br48
Reluctant Surgeon: John Hunter br534
Relyea, George M.† 137
Renal Biopsy br494
Research and Medical Schools (Stetten, Jr.) 488, e255
Research Piper and the Research Tune e373
Research, Responsibility—Furst; Furst *229
Research, A Stop Street to Medical e182
Research Without Animals e413
Resection of Perforated Colonic Lesions—Ryan *480
Reserpine Sensitivity, Ocular Pathology in—Raymond *417
Resolutions 315
Respiratory Disease Abstracts 49, 97, 141, 179, 221, 253, 455, 495, 535, 577
Respiratory Project e458
Retino-Cerebral Re-Education—Rubin *420
Revitch, Eugene, M.D.; Plainfield *145, *541
Rheumatic Heart Disease br412
Robbins, Eugene† 533
Roberts, M. A., M.D.; Newark *15
Robie, Theodore R., M.D.; East Orange *547
Robins, Bernard, M.D.; Westfield *428
Roecker, Roland D., M.D., Summit 218
Rosen, Frank L., M.D.; Maplewood 43
Rosenthal, Aaron M., M.D.; Trenton *109
Ross, Ira S., M.D.; South Orange 43
Rubin, Abraham A.† 493
Rubin, William, M.D.; New Brunswick *420
Rupture of the Gravid Uterus—Brisco; Cicalese *510
Ryan, R., M.D.; Trenton *183

S

Sabety, Adrian M., M.D.; East Orange *241, *424
Safety Belts 503
Salasin, Samuel† 410
Salerno, Felix, M.D.; Dallas, Texas *435
Salmon, George G., Jr., M.D.; Short Hills *188
Salute to Old Timers 38
Salvati, Eugene P., M.D.; Plainfield *105
Santangelo, Emil L.† 92
Savage, Eric† 452
Schizophrenic, Treatment of the Ambulatory—Garber *235
Schmiege, Gustav R., Jr., M.D.; Haddonfield *203
Schnee, I. M., M.D.; Paterson *28
School Child, Hearing Problems of the—Goldstein *431
School Children and Smoking Habits—Kuvin *415
Schwarz, Berthold E., M.D.; Montclair 453
Schwarz, Henry J., Jr., M.D.; North Bergen *82
Scientific Exhibits 167
Scientific Section Meetings 155
Septal Defect, Atrial—Sabety; Masterson, Gelman; Gerard *424
Seton Hall Respiratory Project e458
Shock—Pathogenesis and Therapy br454
Shull, John V.† 217
Silver, Stuart R., M.D.; Orange *241
Sinexon, Henry L.† 45
Skin Disease, Radiation in—Brauer *24
Smokers Withdrawal ab466
Smoking Exhibits 526
Smoking Habits of School Children—Kuvin *415
Smoking and Streptococci ab462
Society, Errant Ways of Human br138
Sodium Concentration in Drinking Water—Braun; Florin *504
Sommer, George N. J., Jr., M.D.; Trenton *31
Southard, Samuel C., M.D.; Ventnor *232
Spinnler, Henry Robert† 410
Stapes Surgery—Boyers *58

* Original Article
† Obituary
e—Editorial
br—Book Review

ab—Abstract
Annual Reports: July JOURNAL
Transactions: July JOURNAL

Stapes Surgery, Present Status of—Noguera; Haase *121
Staphage Lysate Therapy—Salmon, Jr.; Symonds *188
Sterilization, Prognosis After br95
Stetten, DeWitt, Jr., M.D.; New Brunswick 488
Stevens-Johnson Disease in Infants—Hanfling; Nevius *555
Stroke in Camden County—Florin; Rosenthal *109
Suicide and Mass Suicide br411
Supreme Court Decision re MSP 403
Surgeons, Work Output of ab69
Surgery, Geriatric—Roberts *15
Surgery, Fundamental Skills in br454
Surgical Anatomy of the Colon, Rectum, and Anal Canal br219
Surgical Operations, Atlas of br96
Swerdlow, Dave B., M.D.; Orange *518
Symonds, Margaret, M.B., B.S.; New Vernon *188
Syringes, Universal Calibre for ab57
Szymanski, John J.† 493

T

Technical Exhibits 172
Teeth, Psychosomatic Aspects ab72
Telepathy, Beyond br148
Tetanus Immunization 135
Therapy 1962 and 1963 br48, br569
Therapy Through Music and the Arts—Thompson *467
Thompson, Charles M., M.D.; Phila., Pa. *194
Thompson, Myrtle Fish, B.A.; Cedar Grove *467
Thoracic and Cardiovascular Surgery with Related Pathology br220
Thoracic Injuries, Tracheotomy—Sommer, Jr. *31
Thrombosis, Intra-Arterial—Gelman; Silver; Sabety *241
Tillis, Herman H., M.D.; East Orange *200
Tinea Versicolor, Treatment of—Giordano *186
Tobacco Advertising 134
Tobacco Exhibits 526
Tomorrow's Miracle br149
Toxic Megacolon—Gelber; Lewis *54
Tracheotomy in Chest Injuries—Sommer, Jr. *31
Traffic Accidents: 1962 e256
Transactions of the House of Delegates 257
Tranquilizers' Intoxication—Homer *115
Trustees, Board of, Meetings—
October 21, 1962 35
November 18, 1962 90
January 20, 1963 132
February 17, 1963 209
March 17, 1963 214
April 21, 1963 249
May 10, 1963 400
May 15, 1963 400
June 16, 1963 447
July 21, 1963 490
September 15, 1963 525
October 20, 1963 565
Tuberculosis and Health Association e537
Tumor Viruses of Murine Origin br411
Tympanoplasty, Technics of—Schnee *28
Tyndall, Hugh H.† 217

U

Ulcerative Colitis—Salvati *105
Ulcerative Colitis and Toxic Megacolon—Gelber; Lewis *54
Ulvestad, Lawrence, M.D.; Orange *518
Uterus, Rupture of the Gravid—Brisco; Cicalese *510

V

Vaccinia Immune Globulin 240
Van Winkle, Charles I.† 410
Vasa Previa—Reisfield *385
Vitamins, Multiple Danger of—Haynes, Jr. *477

W

Wadsworth, Walter A.† 493
Wakeley, W. E.† 217
Walker, Dr. Mary br220
Walsh, Thomas J.† 493
Waters, They Took to the br252
Weed, Jefferson† 410
Wegryn, Louis S., M.D.; Elizabeth *5, 247
Wheeler, Kenneth W.† 410
Whittaker, Neil McLeod† 410
Wigs e2
Williams, William Carlos† 217
Winter, Carl M.† 45
Winter, Arthur, M.D.; East Orange *8
Wolfe, Elliott S., M.D. 43
Woman's Auxiliary Annual Meeting 178
Women and Fatigue br48
Workmen's Compensation, Selection of Physician 132

Z

Zinc Insulin Combinations—Robins *428

1- 50—Jan.
51- 98—Feb.
99-142—March
143-180—April
181-222—May
255-372—July
255-372—July
373-412—Aug.
413-456—Sept.
457-496—Oct.
497-536—Nov.
537-578—Dec.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

DECEMBER, 1963 • VOL. XXXVI, NO. 10

EMPHYSEMA, HYPOXIA, AND THE POLYCYTHEMIC RESPONSE

The effect of oxygen deficiency on the red blood cells in patients with emphysema was compared with red-blood cell levels in people living at high altitudes. Levels were found to be lower in the emphysematous patient than in the normal high-altitude dweller.

In normal persons chronic hypoxia results in polycythemia. This phenomenon has been recognized and studied in high-altitude dwellers, and data obtained from such studies have come to be accepted as the normal response to hypoxia.

Patients with cyanotic congenital heart disease have hemoglobin and hematocrit levels close to those of normal high-altitude dwellers, while many patients with chronic hypoxic lung disease have much lower levels than might be expected from the degree of hypoxia present.

The present study was designed to investigate the hematologic response to hypoxia in emphysematous patients, and to compare this with that of normal high-altitude dwellers and patients with cyanotic congenital heart disease.

Eighteen unselected patients (17 men, 1 woman) with hypoxia due to chronic pulmonary emphysema and records of 160 other patients with chronic lung disease were studied in detail.

The most marked abnormality in pulmonary function was in the mechanics of breathing. All patients had hypoxemia at rest, and carbon dioxide retention was present in most. In the hematologic studies, the hemoglobin and hematocrit levels showed an inconstant response to hypoxia. In all cases the MCHC (mean corpuscular hemoglobin concentration) was below normal. However, the red cells appeared only minimally hypochromic, and there was not the marked variation in size and shape of the red cells with microcytosis characteristic of iron-deficiency anemia. Reticulocyte counts were normal.

In patients with cyanotic congenital heart diseases and those with emphysema, hemoglobin and hematocrit levels are below those expected in normal persons at altitude. The discrepancy is greater in emphysematous patients than in those with congenital heart disease.

HEMOGLOBIN LEVELS IN EMPHYSEMA

Within similar ranges of arterial oxygen saturation, the standard deviation of hemoglobin levels in emphysematous patients differs little from those obtained in low-altitude dwellers. Thus, emphysematous patients are less "polycythemic" than one might have anticipated. The difference between mean hemoglobin levels of normal dwellers at high altitude and those of emphysematous patients at sea levels becomes progressively greater with increasing hypoxia.

In healthy high-altitude dwellers a rise in red-cell volume will result in a proportional increase in the venous hematocrit. Emphysematous patients, however, often have a high plasma volume which obscures the rise of red-cell volume. Since it has been shown that car-

THERESA VANIER, M.B.; MAURICIO J. DULFANO, M.D.; CLYDE WU, M.D.; and JANE F. DESFORGES, M.D., *The New England Journal of Medicine*, July 25, 1963.

diac output is not increased in such patients, less hemoglobin and therefore less oxygen are transported to their tissues per unit of time than in high-altitude dwellers, whose cardiac output has also been found to be normal.

In emphysematous patients with a low MCHC, red-cell morphology is not grossly abnormal except for a slight elevation of mean corpuscular volume and in this way differs from cases of simple iron deficiency. Although half the patients with cyanotic congenital heart disease in the present series had an MCHC below normal, there was no relation between this and figures for arterial oxygen saturation, and relative iron deficiency is the most probable explanation for such findings.

PLASMA IRON TURNOVER

In normal persons acute hypoxia such as occurs on arrival at high altitude results in an increased plasma iron turnover, the change being mainly due to a more rapid clearance of iron from the plasma. Conversely, descent from high altitude to sea level will result in a progressive fall in iron turnover.

In only two of the four emphysematous patients subjected to four to six days' oxygenation was there a marked fall in iron turnover. When an acute hypoxic state was produced by withdrawal of oxygen, one patient showed a marked increase in iron turnover. In the other three the plasma iron turnover failed to increase. In all cases infection is believed to have complicated the picture.

Emphysematous patients differ from normal high-altitude dwellers and patients with cyanotic heart disease in two obvious ways that might account for their inability to produce a normal hemoglobin mass.

In the first place, pCO_2, which is usually low in the two latter groups, is usually high in hypoxic emphysematous patients. In the second place, most emphysematous patients have accompanying chronic bronchitis manifested by chronic cough and daily expectoration. One could assume that chronic infection is present in the bronchial tree even in the absence of ancillary signs of infection.

Emphysematous patients are also subjected to repeated acute infections. It seems likely that the constant presence of chronic inflammation combined with recurrent acute infections in the lung plays some part in preventing an appropriate erthropoietic response to hypoxemia.

CONCLUSIONS

Mean values for both hemoglobin and hematocrit are abnormally low in hypoxic emphysematous patients at sea level when compared to those of normal high-altitude dwellers. At comparative levels of hypoxic range the response of patients with congenital heart disease falls between that of high-altitude dwellers and emphysematous patients.

In hypoxic emphysematous patients the red-cell volume increases as arterial oxygen desaturation becomes marked, but this value is also lower than the degree of hypoxia leads one to expect.

At any level of arterial oxygen saturation the scatter of individual hemoglobin, hematocrit, and red-cell volume is similar in both normal high-altitude dwellers and patients with emphysema, and becomes widest below 85 per cent of arterial oxyhemoglobin saturation. The response of the patient, whether normal or abnormal, appears progressively less predictable under conditions of increasing chronic hypoxic stress.

Many emphysematous patients have an increased plasma volume although heart failure may not be obvious clinically. An increase in red-cell volume may fail to be reflected in the venous hematocrit level because of the presence of an increased plasma volume.

The low mean corpuscular hemoglobin concentration observed in hypoxic emphysematous patients appears to be related inversely to carbon dioxide retention.

New Jersey Tuberculosis and Health Association

15 East Kinney Street, Newark 2, New Jersey



The Lady Governors of the Old Men's Home at Haarlem FRANS HALS, 1580/81-1666

In Geriatrics...

METAMUCIL® Provides Bland Smoothage

brand of psyllium hydrophilic mucilloid

The tendency of the elderly to subsist on low-residue foods often is a prime cause of bowel sluggishness. Adequate fecal content is necessary to maintain normal colonic function, since intracolonic distention is nature's method of stimulating reflex peristalsis.

Metamucil, therefore, fulfills a basic function in the treatment of geriatric constipation. It both softens hard, dehydrated fecal concretions and adds smooth, nonirritant, easily compressible hydrophilic bulk.

Metamucil applies a physiologic principle to correct constipation naturally.

Average Adult Dose: One rounded teaspoonful of Metamucil powder (or one packet of Instant Mix Metamucil) in a glass of cool liquid. To Metamucil powder, a refined, purified and concentrated psyllium hydrophilic mucilloid, an equal amount of dextrose is added as a dispersing agent. Each dose of the powder furnishes a negligible amount of sodium and 14 calories. To the mucilloid in Instant Mix Metamucil citric acid, sodium bicarbonate and mild flavoring are added. Each dose of Instant Mix Metamucil furnishes 0.25 Gm. of sodium and 3 calories. Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons of 16 and 30 single-dose packets.

G. D. SEARLE & CO.
CHICAGO, ILLINOIS, 60680
Research in the Service of Medicine



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE MARK

"Prescribe With Confidence"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

MILLER Barefoot Freedom®

SOLD ON Rx ONLY

CORRECTIVE FOOTWEAR FOR MEN - WOMEN - CHILDREN

OUTFLAIR SHOES FOR CLUB FEET

69 WESTWOOD AVENUE
WESTWOOD, N. J.

350 MAIN STREET
HACKENSACK, N. J.

Dennis Brown Splints — In all sizes — Carried in stock

CUSTOM SHOE SHOP ON PREMISES

NOW! DIABETICS CAN ENJOY
(UNDER MEDICAL ADVICE)

Abbotts

ARTIFICIALLY SWEETENED

ICE CREAM

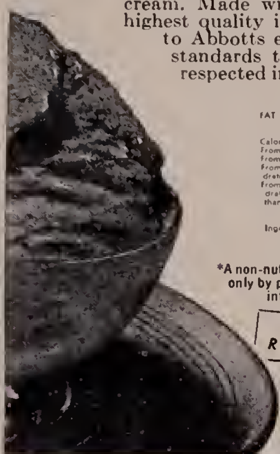
Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards—standards that are most highly respected in the dairy industry

COMPOSITION
FAT 10 52% PROTEIN 3.71%
CARBOHYDRATES 20 40%

Calories — Per	100 Gm.	Oz Avoir.	Oz Fluid
From Fat	94 68	26 84	16 25
From Protein	14 84	4 21	2 55
From Carbohydrates as Lactose	20 24	5 74	3 47
From Carbohydrates other than Lactose	61 66	17 48	10 58
	191 42	54.27	32 85

Ingredients: Cream, Milk, Sorbitol, Stabilizer and 0.11% Cyclamate Calcium*

*A non-nutritive artificial sweetener for use only by persons who must restrict their intake of ordinary sweets.



IN HANDY ROUND PINTS

At Abbotts
and Jane Logan Dealers
Abbotts Dairies

SHIP TO SHORE
RADIO TELEPHONE

CHARLES W. ROGERS & SON

Tel. 223-1949 **Tel. 223-1953**

Manasquan, New Jersey

RADIOTELEPHONES — RADAR

LORAN — DIRECTION FINDERS

DEPTH RECORDERS

SHORE CONVERTERS

Over 1/3 Century of Technical Know How



planned by professionals . . .
for professionals . . .
with dignity aand fine taste

You are invited to visit our extensive showrooms and to discuss your plan with a member of our design staff.

- interior designs
- space planning
- office furniture
- equipment
- accessories

the w.b. wood company

43 clinton street **newark, n. j.**
market 3-7900

WALKER-GORDON CERTIFIED SKIMMED MILK

Made by simply removing the cream from Certified Whole Milk, the highest-quality, cleanest Milk ever produced. Tastes delicious . . . uniform flavor the year-around . . . thus minimizing patient's normal resistance to Skimmed Milk intake. *Guaranteed free of antibiotic residue.* Write for more information.

Now in individual half-pint paper containers for hospitals, hotels, restaurants

WALKER-GORDON CERTIFIED MILK FARM
Plainsboro, N. J. • 609 SWinburne 9-1234
New York: 212 WAlker 5-7300 • Phila.: 215 PEnnpacker 5-3465

Also Certified Raw, Pasteurized, Homogenized-Vit. D, Acidophilus and Fresh Lo-Sodium Milks; available through leading Milk Dealers or call Walker-Gordon.

The Morristown Rehabilitation Center

66 MORRIS STREET MORRISTOWN, NEW JERSEY
JEFFERSON 9-3000



NATHAN KAPLAN, M.D., Physiatrist
MARY E. JOHNSON, Chief Therapist
ANN G. McMANUS, R.N.
Director of Nursing Service
AUDREY E. TAHLMORE
Administrator

A 38-bed rehabilitation unit specializing in orthopedic and neurological disabilities. Speech therapy, Occupational therapy and psychological evaluation available

AMERICAN HOSPITAL ASSOCIATION ACCREDITATION
MEMBER NEW JERSEY LICENSED NURSING HOME ASSOCIATION

BRUNSWICK PARK NURSING HOME

NEW JERSEY'S NEWEST, MOST MODERN HOME FOR THE CONVALESCENT, CHRONICALLY ILL AND AGED



NOW OPEN!

NO STEPS TO CLIMB!

REASONABLE RATES

INSPECTION INVITED

- Referring physicians have full medical privileges
- Physical and recreational therapy program
- Experienced professional staff
- Special diets
- Complete 24-hour general nursing care
- Audio-Visual Nurses' call system for every bed
- Air-conditioned
- Private & semi-private rooms
- Sanitary all-stainless steel kitchen, tiled to ceiling
- Tiled wheel-in showers and baths
- Piped-In music
- Spacious outdoor patios

ON U.S. 1 AT INTERSECTION N. J. 18 (Opposite Howard Johnson's)

Tel. (201) 828-2400 Licensed by State of New Jersey **NEW BRUNSWICK, N. J.**

LONG TERM AUTO LEASING

. . . A SERVICE ESPECIALLY PLANNED FOR DOCTORS!

M.D. PLATES FREE, TOO!

LONG TERM SINGLE CAR AND FLEET RENTALS

Call ORange 6-7137 or MAIL COUPON TODAY

Lease a brand new Cadillac or other fine car from American and you'll never **buy** again. Save money, time and trouble. One modest monthly payment takes care of everything . . . insurance, maintenance, repairs, depreciation . . . and the payments are 100% tax deductible! Borrow a car—free of charge—in case of accident or breakdown.

INCLUDES

- Registration and plates
- Full maintenance
- Insurance

Liability $250/$500,000
Property damage $20,000
Deductible collision, fire and theft

AMERICAN AUTO LEASING COMPANY
120 Halsted St., East Orange, N. J.
Please send me the AAL Long Term Leasing Plan.

Wide Selection of '63 Models

Special requirements _____

_____

Name _____

Address _____

City _____ State _____

ALL YOU BUY IS GAS AND OIL

ASK FOR BROCHURE

AMERICAN AUTO LEASING COMPANY

120 Halsted Street, East Orange, New Jersey • ORange 6-7137

CLASSIFIED ADVERTISEMENTS

Send replies to box number, c/o THE JOURNAL
P. O. Box 904, Trenton, New Jersey 08605

$5 for 25 words or less; additional words 10c each
Payable in advance of publication

Forms close 15th of the preceding month.

ASSOCIATE WANTED — Young internist (cardiologist) desires associate, preferably gastroenterologist, for the practice of internal medicine, primarily in hospital setting. Thirty minutes from Philadelphia. Opportunity for academic affiliation. Write Box No. 82, c/o THE JOURNAL.

CHILD PSYCHIATRY—Inpatient setting for emotionally disturbed children in latency and early adolescent age range needs physician to assist in psychiatric evaluation and therapy. Some general pediatric work. Staff includes several physicians, psychologists, and social workers. Active and dynamically oriented program. Salary determined by training, experience, and license status. Liberal fringe benefits. New Jersey license preferred. ECFMG certificate required of foreign graduate. Write Box No. 90, c/o THE JOURNAL.

GENERAL PRACTITIONER—Small group. Northern New Jersey metropolitan area. Experienced. Salary with eventual partnership. Internist would also be considered. Write Box No. 78, c/o THE JOURNAL.

GENERAL PRACTITIONER—Age 34. Desires young associate in active general practice in central shore area. Partnership in one year. Full particulars in reply. Write Box No. 89, c/o THE JOURNAL.

OPHTHALMOLOGIST—Wanted to occupy office in new medical building in desirable New Jersey suburban community adjacent Philadelphia. Hospitals nearby. Building currently houses offices for seven other medical specialists. Write Box No. 87, c/o THE JOURNAL.

OPHTHALMOLOGIST WANTED—Board certified or qualified, to take over active suburban New York area practice. Spacious office with attractive apartment available. Write Box No. 94, c/o THE JOURNAL.

PHYSICIANS WANTED—Fast-growing Plainfield residential area needs general practitioner, specialists. Offices, suites for immediate occupancy. New brick colonial professional building. (201)-755-4433, Dr. Eyrich; or write Box No. 92, c/o THE JOURNAL.

WANTED—Well-trained general practitioner or internist to join long-established general practitioner with large practice. New, fully equipped building. Fine hospital. One year salary, then partnership. Leo Lewin, M.D., Mount Arlington, New Jersey. Phone: 398-0870.

GENERAL PRACTITIONER—Desires part or full-time position with insurance company, industry, or any other institution. Extensive experience as Associate Gynecologist in local hospital. In Newark or vicinity. Write Box No. 93, c/o THE JOURNAL.

OBSTETRICIAN-GYNECOLOGIST—32, Board eligible, Protestant, married. Completes service obligation in summer of 1964. Desires association with established OB practice. Write Box No. 91 c/o THE JOURNAL.

DOCTOR LEAVING STATE—For retirement practice. For Sale: Clifton, New Jersey (convenient to Lincoln Tunnel and Garden State Parkway). Established EENT's country-contemporary house and spacious office in fine residential area. Completely separate entrance on corner lot 200 x 124 with ample parking, 2-car garage. Three-way living-kitchen, 3½ baths, 2 fireplaces, 3 bedrooms, mirrored dressing-room, large living-dining room with cathedral ceiling, study. Completely air-conditioned with roll screens. Beautifully landscaped, privacy for outdoor living. Call owner: mornings between 9:00 and 10:00. PR 9-3202.

PRACTICE FOR SALE—25-year-old practice for internist or general practitioner in Monmouth County, New Jersey; beautiful 5-year-old brick home and large 5½-room office; including 100 Ma. x-ray, all new equipment, air-conditioned. Sudden death of physician. Gross well over $50,000. Financing arranged or salary basis. H. M. Swartz, M.D., 138 Cherry Tree Farm Road, Middletown, New Jersey. OS 1-3313.

PRIVATE PRACTICE—Available January 1, 1964. Will introduce. Take over for value of property only; residence, equipped office, etc. $19,000 with terms to suit. Address inquiries: Doctor, P. O. Box 226, Asbury Park, New Jersey.

RADIOLOGY PRACTICE FOR SALE—With or without building, North Hudson area, Hudson County, New Jersey. Radiologist in failing health. Gross income easily $40,000. Good also for gastroenterologist or x-ray minded general practitioner. Send replies to Box No. 335, c/o Main Post Office, Union City, New Jersey.

FOR SALE—Immediately. Growing Internal Medicine practice. Expanding North Jersey suburb needing Internist. Completely equipped. Strategic new multi-specialty professional building. Open staff hospital. Returning to academic post. Call: 201-391-7799.

CLASSIFIED (Continued)

CERTIFIED NEUROLOGIST—Eligible in psychiatry, desires association with a group or individual. Experienced in EEG, EMG, angiography, myelography, etc. New Jersey license. Write Box No. 79, c/o THE JOURNAL.

ENT AND ALLERGY—In upstate New York in the foothills of the Adirondacks. Good fishing and hunting. Retiring because of old age. Excellent opportunity for younger, active man. Open hospital. New hospital in advanced planning stage. Write Box No. 95, c/o THE JOURNAL.

EXCELLENT HOME & OFFICE—For doctor. Located in Passaic's most exclusive area near similar professional dwellings. $32,800. Richard Terry Agency, Broker, 730 Broad Street, Clifton, New Jersey.

OFFICES AVAILABLE—Now in a modern, fully air-conditioned, bi-level medical building which is ideally located in suburban New Jersey, in the fastest growing residential and industrial community of the greater New York area. This newly constructed building will consist of approximately five suites with adjacent off-street parking facilities. Suites custom built. Immediate occupancy. FU 1-3738.

OFFICE TO SHARE—Upper Montclair. Completely equipped; air conditioned; 500 ma. x-ray; EKG, etc. PI 4-3636.

IRVINGTON—600 square foot suite remaining in new professional building, presently occupied by dentist, allergist, optometrist, and speech therapist. 1146 Stuyvesant Avenue. ES 3-1073, MU 6-0787.

FOR RENT—Demarest, New Jersey. New medical office, well located residential area Bergen County. Central air-conditioning and heating. 201—PO-8-8687.

FOR RENT—Medical office in new modern professional building in Dover area of Morris County. Will partition to suit. Occupancy on or about June 1. Call or write Robert L. Blake, D.D.S., 44 West Main Street, Rockaway, New Jersey, OA 7-2186.

FOR RENT—For medical-dental offices, 271 Mountain Avenue, Springfield, New Jersey. Two floors, three rooms each; prominent, convenient location; available as residence. Telephone AD 2-5183; or write M.C.K. Jones, Ph.D., Far View Drive, Mountainside, New Jersey.

POSITION WANTED—Medical Assistants and Secretaries. Laboratory and X-Ray Techs. September and February graduation. Well trained and highly qualified personnel (male and female) also available at other times. Phone CH 2-2330, Ext. 17, Placement Department; or write Physician Director, Eastern School for Physicians' Aides, Dept. 7, 85 Fifth Avenue, New York 3, New York.

GREENLEAF FUNERAL HOME

108 WEST PALISADE AVENUE
ENGLEWOOD, N. J.

LO 8-0416 Est. 1893

ORANGE PUBLISHING CO.

PRINTERS

116 LINCOLN AVENUE ORANGE, NEW JERSEY

CHANGE OF ADDRESS

In the event of a change of address or failure to receive THE JOURNAL regularly, fill out this coupon and mail at once to

THE MEDICAL SOCIETY OF NEW JERSEY, P.O. Box 904, Trenton, N. J. 08605

Change my address on mailing list

From .....

To .....

Date ..... Signed .... M.D.



Helps to make the epileptic's life more meaningful

Dilantin® Kapseals®
(Diphenylhydantoin sodium)

PARKE-DAVIS

With modern, intelligent therapy, epilepsy has an excellent prognosis. "Well over 90 per cent of the patients can be adequately controlled so that they can lead a normal life and take a useful and respectable position in society."[1]

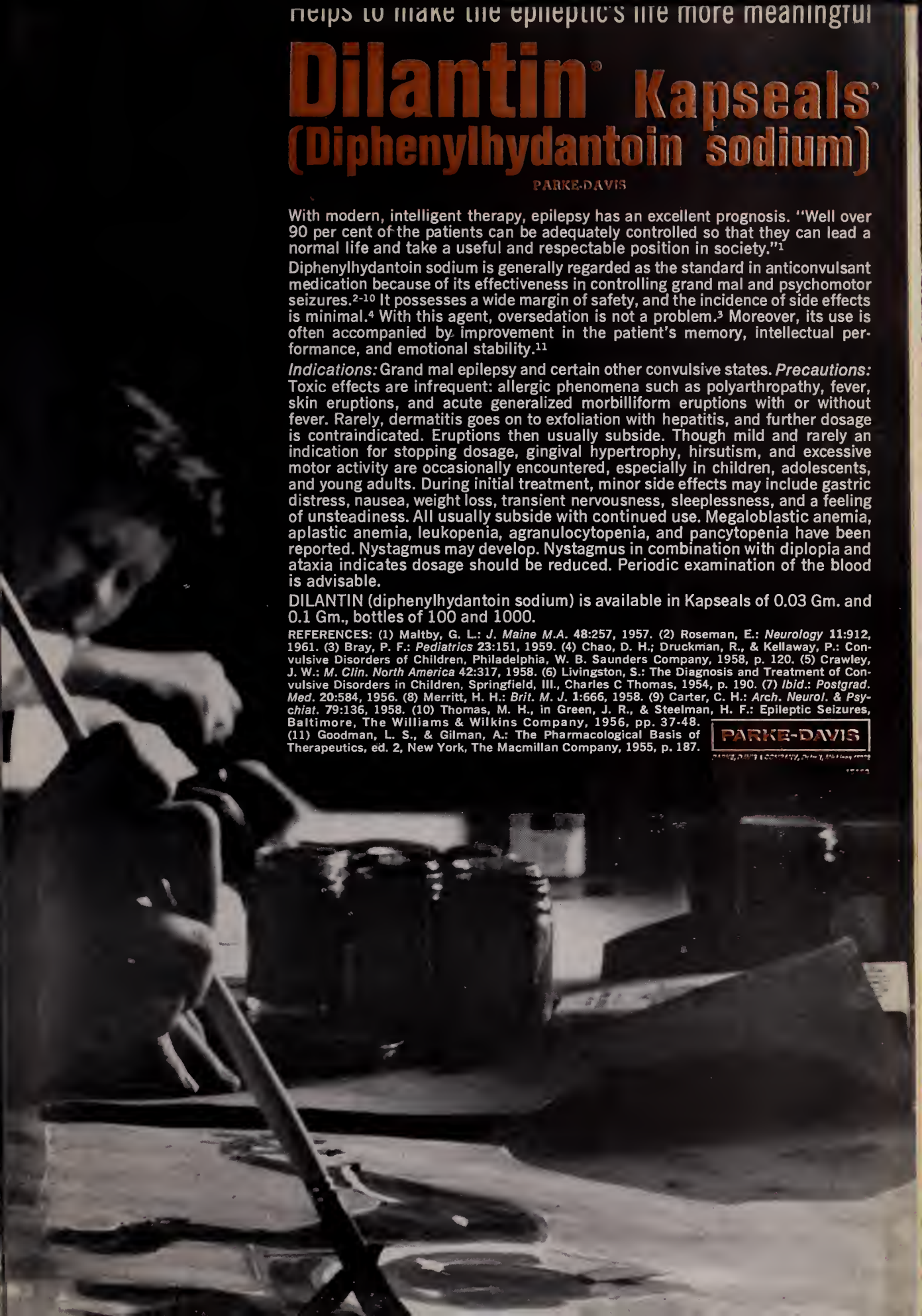
Diphenylhydantoin sodium is generally regarded as the standard in anticonvulsant medication because of its effectiveness in controlling grand mal and psychomotor seizures.[2-10] It possesses a wide margin of safety, and the incidence of side effects is minimal.[4] With this agent, oversedation is not a problem.[3] Moreover, its use is often accompanied by improvement in the patient's memory, intellectual performance, and emotional stability.[11]

Indications: Grand mal epilepsy and certain other convulsive states. *Precautions:* Toxic effects are infrequent: allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Eruptions then usually subside. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Megaloblastic anemia, aplastic anemia, leukopenia, agranulocytopenia, and pancytopenia have been reported. Nystagmus may develop. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. Periodic examination of the blood is advisable.

DILANTIN (diphenylhydantoin sodium) is available in Kapseals of 0.03 Gm. and 0.1 Gm., bottles of 100 and 1000.

REFERENCES: (1) Maltby, G. L.: *J. Maine M.A.* 48:257, 1957. (2) Roseman, E.: *Neurology* 11:912, 1961. (3) Bray, P. F.: *Pediatrics* 23:151, 1959. (4) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (5) Crawley, J. W.: *M. Clin. North America* 42:317, 1958. (6) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (7) *Ibid.*: *Postgrad. Med.* 20:584, 1956. (8) Merritt, H. H.: *Brit. M. J.* 1:666, 1958. (9) Carter, C. H.: *Arch. Neurol. & Psychiat.* 79:136, 1958. (10) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (11) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.

PARKE-DAVIS



anxiety
anxiety
anxiety
anxiety
anxiety
anxiety
anxiety
anxiety
anxiety
anxiety
anxiety reduced to its proper perspective

LIBRIUM®
(chlordiazepoxide HCl)
the successor
to the tranquilizers

6118-35-1

ROCHE

In prescribing: Dosage—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. Cautions—Occasional side effects, often dose-related, are drowsiness, ataxia, minor skin rashes, menstrual irregularities, nausea and constipation. Paradoxical reactions may occasionally occur in psychiatric patients. Individual maintenance dosages should be determined. Advise patients against possibly hazardous procedures until maintenance dosage is established. Though compatible with most drugs, use care in combining with other psychotropics, particularly MAO inhibitors or phenothiazines; warn patients of possible combined effects with alcohol. Observe usual

The New York Academy of Medicine

DUE IN TWO WEEKS UNLESS RENEWED
NOT RENEWABLE AFTER 6 WEEKS

DATE BORROWED	BORROWER
~~MAR 12 1964~~	~~[illegible]~~
~~JUN 15 1964~~	~~[illegible] Hosp.~~
~~AUG [illegible]~~	~~[illegible]~~
~~[illegible]~~	~~[illegible]~~